



**July 2024**

**HAP CareSource  
Formulary Drug List**

## Your Drug Coverage

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

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

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

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

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

## Drug Coverage Information

### Formulary list and restrictions

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

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

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

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

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

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

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

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

### Benefit limitations

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

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

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

# HAP CareSource Preferred Drug List

## Table of Contents

ANTIDOTE THERAPEUTICS.....	5
ANTIHISTAMINE DRUGS.....	5
ANTI-INFECTIVE AGENTS.....	9
ANTINEOPLASTIC AGENTS.....	20
ANTITOXINS,IMMUNE GLOB,TOXOIDS,VACCINES.....	23
AUTONOMIC DRUGS.....	25
BLOOD FORMATION, COAGULATION, THROMBOSIS.....	33
CARDIOVASCULAR DRUGS.....	43
CENTRAL NERVOUS SYSTEM AGENTS.....	68
DENTAL AGENTS.....	88
DEVICES.....	88
DIAGNOSTIC AGENTS.....	91
ELECTROLYTIC, CALORIC, AND WATER BALANCE.....	91
ENZYMES.....	99
EYE, EAR, NOSE AND THROAT (EENT) PREPS.....	99
GASTROINTESTINAL DRUGS.....	108
HEAVY METAL ANTAGONISTS.....	121
HORMONES AND SYNTHETIC SUBSTITUTES.....	121
IMMUNOMODULATORY AGENT (90:00).....	142
MISCELLANEOUS THERAPEUTIC AGENTS.....	148
NONHORMONAL CONTRACEPTIVES.....	151
OXYTOCICS.....	152
RESPIRATORY TRACT AGENTS.....	152
SKIN AND MUCOUS MEMBRANE AGENTS.....	160
SMOOTH MUSCLE RELAXANTS.....	174
VITAMINS.....	175

**CURRENT AS OF 7/1/2024**

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<b>ANTIDOTE THERAPEUTICS</b>		
<b>ANTIDOTE THERAPEUTICS</b>		
BAQSIMI	Tier 2	QL (2 Devices per 30 days)
CHEMET	Tier 1	
GLUCAGEN HYPOKIT	Tier 2	
GLUCAGON (HCL) EMERGENCY KIT	Tier 3	PA; QL (6 EA per 1 Fill)
GLUCAGON EMERGENCY KIT (HUMAN)	Tier 2	QL (6 EA per 1 Fill)
GVOKE	Tier 3	PA; QL (0.4 ML per 30 days)
GVOKE HYPOPEN 1-PACK	Tier 2	QL (2 syringes per 30 days)
GVOKE HYPOPEN 2-PACK	Tier 2	QL (2 syringes per 30 days)
GVOKE PFS 1-PACK SYRINGE SUBCUTANEOUS SYRINGE 1 MG/0.2 ML	Tier 3	PA; QL (2 syringes per 30 days)
GVOKE PFS 2-PACK SYRINGE SUBCUTANEOUS SYRINGE 1 MG/0.2 ML	Tier 3	PA; QL (2 syringes per 30 days)
<i>hyoscyamine sulfate oral</i>	Tier 1	AGE (Max 64 Years)
<i>hyoscyamine sulfate sublingual</i>	Tier 1	AGE (Max 64 Years)
<i>phytonadione (vitamin k1) oral tablet 5 mg</i>	Tier 1	QL (3 tablets per 30 dayss)
<b>CHEMEMOTHERAPY</b>		
<b>ANTIDOTES/PROTECTANTS</b>		
ELMIRON	Tier 1	PA; QL (3 capsules per 1 day)
<i>leucovorin calcium oral</i>	Tier 1	
MESNEX ORAL	Tier 1	
<b>ANTIHISTAMINE DRUGS</b>		
<b>ETHANOLAMINE DERIVATIVES</b>		
ALLER-G-TIME	Tier 1	AGE (Max 64 Years)
ALLERGY RELIEF(DIPHENHYDRAMIN) ORAL TABLET	Tier 1	AGE (Max 64 Years)
BANOPHEN ORAL TABLET	Tier 1	AGE (Max 64 Years)
DAYHIST ALLERGY	Tier 1	
<i>dimenhydrinate oral</i>	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>diphenhydramine hcl injection solution 50 mg/ml</i>	Tier 1	AGE (Max 64 Years)
<i>diphenhydramine hcl injection syringe</i>	Tier 1	AGE (Max 64 Years)
<i>diphenhydramine hcl oral capsule</i>	Tier 1	AGE (Max 64 Years)
<i>diphenhydramine hcl oral liquid</i>	Tier 1	
<i>diphenhydramine hcl oral tablet</i>	Tier 1	AGE (Max 64 Years)
<b>FIRST GEN. ANTIHIST. DERIVATIVES, MISC.</b>		
<i>cyproheptadine</i>	Tier 1	AGE (Max 64 Years)
<b>FIRST GENERATION ANTIHISTAMINES</b>		
ALLER-CHLOR	Tier 1	
ALLER-G-TIME	Tier 1	AGE (Max 64 Years)
ALLERGY (CHLORPHENIRAMINE)	Tier 1	
ALLERGY RELIEF(CHLORPHENIRAMN)	Tier 1	
ALLERGY RELIEF(DIPHENHYDRAMIN) ORAL TABLET	Tier 1	AGE (Max 64 Years)
ALLERGY-TIME	Tier 1	
BANOPHEN ORAL TABLET	Tier 1	AGE (Max 64 Years)
<i>carbinoxamine maleate oral liquid</i>	Tier 1	
<i>carbinoxamine maleate oral tablet 4 mg</i>	Tier 1	
<i>chlorpheniramine maleate oral tablet</i>	Tier 1	
<i>chlorpheniramine maleate oral tablet extended release</i>	Tier 1	
CHLORTABS	Tier 1	
<i>cyproheptadine</i>	Tier 1	AGE (Max 64 Years)
DAYHIST ALLERGY	Tier 1	
<i>dimenhydrinate oral</i>	Tier 1	
<i>diphenhydramine hcl injection solution 50 mg/ml</i>	Tier 1	AGE (Max 64 Years)
<i>diphenhydramine hcl injection syringe</i>	Tier 1	AGE (Max 64 Years)
<i>diphenhydramine hcl oral capsule</i>	Tier 1	AGE (Max 64 Years)
<i>diphenhydramine hcl oral liquid</i>	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>diphenhydramine hcl oral tablet</i>	Tier 1	AGE (Max 64 Years)
PHARBECHLOR	Tier 1	
WAL-FINATE	Tier 1	
<b>PHENOTHIAZINE DERIVATIVES</b>		
<i>promethazine oral</i>	Tier 1	AGE (Min 2 Years and Max 64 Years)
<i>promethazine rectal suppository 12.5 mg, 25 mg</i>	Tier 1	QL (4 suppositories per 1 day); AGE (Min 2 Years and Max 64 Years)
<i>promethazine rectal suppository 50 mg</i>	Tier 1	QL (2 suppositories per 1 day); AGE (Min 2 Years and Max 64 Years)
<b>PIPERAZINE DERIVATIVES</b>		
<i>hydroxyzine hcl oral solution 10 mg/5 ml</i>	Tier 1	AGE (Max 12 Years)
<i>hydroxyzine hcl oral tablet</i>	Tier 2	
<i>hydroxyzine pamoate</i>	Tier 2	
<i>meclizine oral tablet 12.5 mg, 25 mg</i>	Tier 1	
<i>meclizine oral tablet, chewable</i>	Tier 1	
VISTARIL ORAL CAPSULE 25 MG	Tier 3	PA
<b>PROPYLAMINE DERIVATIVES</b>		
ALLER-CHLOR	Tier 1	
ALLERGY (CHLORPHENIRAMINE)	Tier 1	
ALLERGY RELIEF(CHLORPHENIRAMN)	Tier 1	
ALLERGY-TIME	Tier 1	
<i>chlorpheniramine maleate oral tablet</i>	Tier 1	
<i>chlorpheniramine maleate oral tablet extended release</i>	Tier 1	
CHLORTABS	Tier 1	
PHARBECHLOR	Tier 1	
WAL-FINATE	Tier 1	
<b>SECOND GENERATION ANTIHISTAMINES</b>		
24HR ALLERGY RELIEF	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

Drug Name	Tier	Restrictions/Limits
ALL DAY ALLERGY (CETIRIZINE) ORAL SOLUTION	Tier 2	
ALL DAY ALLERGY (CETIRIZINE) ORAL TABLET	Tier 2	
ALLER-EASE ORAL TABLET 180 MG	Tier 2	
ALLERGY RELIEF (CETIRIZINE) ORAL CAPSULE	Tier 3	PA
ALLERGY RELIEF (CETIRIZINE) ORAL TABLET 10 MG	Tier 2	
ALLERGY RELIEF (LORATADINE) ORAL SOLUTION	Tier 2	
ALLERGY RELIEF (LORATADINE) ORAL TABLET	Tier 2	
ALLERGY RELIEF (LORATADINE) ORAL TABLET,DISINTEGRATING 10 MG	Tier 2	
<i>cetirizine oral solution 1 mg/ml</i>	Tier 2	
<i>cetirizine oral solution 5 mg/5 ml</i>	Tier 3	PA
<i>cetirizine oral tablet</i>	Tier 2	
<i>cetirizine oral tablet,chewable</i>	Tier 3	PA
CHILD ALLERGY RELF(CETIRIZINE)	Tier 2	
CHILDREN'S ALLERGY RELIEF(FEX)	Tier 2	
CHILDREN'S ALLERGY RELIEF(LOR) ORAL SOLUTION	Tier 2	
CHILDREN'S ALLERGY(CETIRIZINE)	Tier 2	
CHILDREN'S CETIRIZINE ORAL SOLUTION	Tier 2	
CHILDREN'S CETIRIZINE ORAL TABLET,CHEWABLE	Tier 3	PA
CHILDREN'S LORATADINE	Tier 2	
CHILD'S ALL DAY ALLERGY(CETIR)	Tier 2	
CLARINEX ORAL TABLET	Tier 3	PA
<i>desloratadine oral tablet</i>	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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



<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>desloratadine oral tablet, disintegrating 2.5 mg</i>	Tier 3	PA; AGE (Max 11 Years)
<i>desloratadine oral tablet, disintegrating 5 mg</i>	Tier 3	PA
<i>fexofenadine</i>	Tier 2	
<i>levocetirizine oral solution</i>	Tier 3	PA
<i>levocetirizine oral tablet</i>	Tier 2	
<i>loratadine oral solution</i>	Tier 2	
<i>loratadine oral tablet</i>	Tier 2	
<b>ANTI-INFECTIVE AGENTS</b>		
<b>1ST GENERATION CEPHALOSPORIN ANTIBIOTICS</b>		
<i>cefadroxil oral capsule</i>	Tier 2	QL (28 capsules per 1 fill)
<i>cefadroxil oral suspension for reconstitution 250 mg/5 ml, 500 mg/5 ml</i>	Tier 2	
<i>cefadroxil oral tablet</i>	Tier 3	PA; QL (28 tablets per 1 fill)
<i>cephalexin</i>	Tier 2	
<b>2ND GENERATION CEPHALOSPORIN ANTIBIOTICS</b>		
<i>cefaclor oral capsule</i>	Tier 3	PA; QL (42 capsules per 1 fill)
<i>cefaclor oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml, 375 mg/5 ml</i>	Tier 3	PA
<i>cefaclor oral tablet extended release 12 hr</i>	Tier 3	PA; QL (42 tablets per 1 fill)
<i>cefprozil oral suspension for reconstitution</i>	Tier 2	
<i>cefprozil oral tablet</i>	Tier 2	QL (28 tablets per 1 fill)
<i>cefuroxime axetil oral tablet</i>	Tier 2	QL (42 tablets per 1 fill)
<b>3RD GENERATION CEPHALOSPORIN ANTIBIOTICS</b>		
<i>cefdinir oral capsule</i>	Tier 2	QL (28 capsules per 1 fill)
<i>cefdinir oral suspension for reconstitution</i>	Tier 2	
<i>cefixime oral capsule</i>	Tier 2	
<i>cefixime oral suspension for reconstitution</i>	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>cefepodoxime oral suspension for reconstitution</i>	Tier 3	PA
<i>cefepodoxime oral tablet</i>	Tier 3	PA; QL (28 tablets per 1 fill)
<b>ADAMANTANE ANTIVIRALS</b>		
<i>amantadine hcl oral capsule</i>	Tier 2	
<i>amantadine hcl oral solution</i>	Tier 2	
<i>amantadine hcl oral tablet</i>	Tier 3	PA
FLUMADINE ORAL TABLET	Tier 3	PA
GOCOVRI	Tier 3	PA
OSMOLEX ER	Tier 3	PA
<i>rimantadine</i>	Tier 2	
<b>ALLYLAMINE ANTIFUNGALS</b>		
<i>terbinafine hcl oral</i>	Tier 2	QL (84 tablets per 1 fill)
<i>terbinafine hcl topical</i>	Tier 1	
<b>AMEBICIDES</b>		
<i>bismuth subcit k-metronidz-tcn</i>	Tier 3	PA
FLAGYL ORAL CAPSULE	Tier 3	PA
LIKMEZ	Tier 3	PA
<i>metronidazole oral capsule</i>	Tier 3	PA
<i>metronidazole oral tablet</i>	Tier 2	
<i>paromomycin</i>	Tier 1	
PYLERA	Tier 2	
<b>AMINOGLYCOSIDE ANTIBIOTICS</b>		
BETHKIS	Tier 2	
KITABIS PAK	Tier 2	
<i>neomycin</i>	Tier 2	
<i>paromomycin</i>	Tier 1	
TOBI	Tier 3	PA
TOBI PODHALER	Tier 2	
<i>tobramycin in 0.225 % nacl</i>	Tier 2	
<i>tobramycin inhalation</i>	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>tobramycin with nebulizer</i>	Tier 3	PA
<b>AMINOPENICILLIN ANTIBIOTICS</b>		
<i>amoxicil-clarithromy-lansopraz</i>	Tier 3	PA; QL (224 capsules per 1 fill)
<i>amoxicillin oral capsule</i>	Tier 1	
<i>amoxicillin oral suspension for reconstitution</i>	Tier 1	
<i>amoxicillin oral tablet</i>	Tier 1	
<i>amoxicillin oral tablet, chewable 125 mg, 250 mg</i>	Tier 1	
<i>amoxicillin-pot clavulanate oral suspension for reconstitution</i>	Tier 1	
<i>amoxicillin-pot clavulanate oral tablet</i>	Tier 1	
<i>amoxicillin-pot clavulanate oral tablet, chewable</i>	Tier 1	
<i>ampicillin oral capsule 500 mg</i>	Tier 1	
OMECLAMOX-PAK	Tier 3	PA
TALICIA	Tier 3	PA
<b>ANTHELMINTICS</b>		
<i>ivermectin oral</i>	Tier 1	QL (10 tablet per 30 days)
REESE'S PINWORM MEDICINE	Tier 1	
<b>ANTIFUNGALS, MISCELLANEOUS</b>		
<i>griseofulvin microsize oral suspension</i>	Tier 2	
<i>griseofulvin microsize oral tablet</i>	Tier 3	PA
<i>griseofulvin ultramicrosize</i>	Tier 3	PA
<b>ANTILEPROSY AGENTS</b>		
<i>dapsone oral</i>	Tier 1	
<b>ANTIMALARIALS</b>		
<i>bismuth subcit k-metronidz-tcn</i>	Tier 3	PA
<i>chloroquine phosphate</i>	Tier 1	QL (1 tablet per 1 day)
<i>doxycycline hyclate oral capsule</i>	Tier 1	
<i>doxycycline hyclate oral tablet 100 mg</i>	Tier 1	
<i>doxycycline monohydrate oral capsule 100 mg, 50 mg</i>	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>doxycycline monohydrate oral suspension for reconstitution</i>	Tier 1	
<i>doxycycline monohydrate oral tablet 100 mg, 50 mg</i>	Tier 1	
<i>hydroxychloroquine</i>	Tier 1	
KRINTAFEL	Tier 1	PA; QL (2 tablets per 1 year); AGE (Min 16 Years)
<i>mefloquine</i>	Tier 1	PA; QL (5 tablets per 30 days)
<i>primaquine</i>	Tier 1	
PYLERA	Tier 2	
<i>pyrimethamine</i>	Tier 1	PA; QL (3 tablets per 1 day)
<i>quinidine sulfate oral tablet</i>	Tier 1	
<b>ANTIPROTOZOALS, CRYPTOSPORIDIOSIS</b>		
<i>nitazoxanide</i>	Tier 3	PA; QL (6 tablets per 30 days)
<b>ANTIPROTOZOALS, MISCELLANEOUS</b>		
<i>bismuth subcit k-metronidz-tcn</i>	Tier 3	PA
PYLERA	Tier 2	
<b>ANTIPROTOZOALS, P JIROVECI PNEUMONIA</b>		
<i>atovaquone</i>	Tier 1	
<b>ANTIPROTOZOALS, NITROIMIDAZOLE-DERIVATIVE</b>		
<i>tinidazole</i>	Tier 2	
<b>ANTITUBERCULOSIS AGENTS</b>		
CIPRO HC	Tier 3	PA
CIPRO ORAL SUSPENSION, MICROCAPSULE RECON	Tier 2	
CIPRO ORAL TABLET 250 MG, 500 MG	Tier 3	PA; QL (42 tablets per 1 fill)
<i>ciprofloxacin</i>	Tier 2	
<i>ciprofloxacin hcl oral</i>	Tier 2	QL (42 tablets per 1 fill)
<i>clarithromycin oral suspension for reconstitution</i>	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>clarithromycin oral tablet</i>	Tier 2	QL (28 tablets per 1 fill)
<i>clarithromycin oral tablet extended release 24 hr</i>	Tier 3	PA
<i>cycloserine</i>	Tier 1	QL (4 capsules per 1 day)
<i>ethambutol</i>	Tier 1	
<i>isoniazid oral solution</i>	Tier 1	AGE (Max 12 Years)
<i>isoniazid oral tablet</i>	Tier 1	
<i>levofloxacin oral solution</i>	Tier 2	
<i>levofloxacin oral tablet 250 mg, 500 mg</i>	Tier 2	QL (14 tablets per 1 fill)
<i>levofloxacin oral tablet 750 mg</i>	Tier 2	QL (28 tablets per 1 fill)
<i>pretomanid</i>	Tier 1	PA
PRIFTIN	Tier 1	QL (24 tablets per 28 days)
<i>pyrazinamide</i>	Tier 1	
<i>rifabutin</i>	Tier 1	
<i>rifampin oral</i>	Tier 1	
SIRTURO	Tier 1	PA
TRECTOR	Tier 1	
<b>AZOLE ANTIFUNGALS</b>		
CRESEMBA ORAL CAPSULE 186 MG	Tier 3	PA
DIFLUCAN ORAL SUSPENSION FOR RECONSTITUTION 40 MG/ML	Tier 3	PA
DIFLUCAN ORAL TABLET 100 MG, 200 MG	Tier 3	PA
EXTINA	Tier 3	PA
<i>fluconazole oral suspension for reconstitution</i>	Tier 2	
<i>fluconazole oral tablet 100 mg, 200 mg, 50 mg</i>	Tier 2	
<i>fluconazole oral tablet 150 mg</i>	Tier 2	QL (2 tablets per 1 fill)
<i>itraconazole oral capsule</i>	Tier 3	PA; QL (100 EA per 30 days)
<i>itraconazole oral solution</i>	Tier 3	PA; QL (840 ML per 1 fill)
<i>ketoconazole oral</i>	Tier 2	
<i>ketoconazole topical cream</i>	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>ketoconazole topical foam</i>	Tier 3	PA
<i>ketoconazole topical shampoo</i>	Tier 2	
KETODAN	Tier 3	PA
KETODAN KIT	Tier 3	PA
NOXAFIL ORAL	Tier 3	PA
<i>posaconazole oral tablet, delayed release (dr/ec)</i>	Tier 3	PA
SPORANOX ORAL CAPSULE	Tier 3	PA; QL (4 capsules per 1 day)
SPORANOX ORAL SOLUTION	Tier 3	PA; QL (840 ML per 1 fill)
TOLSURA	Tier 3	PA
VFEND	Tier 3	PA
<i>voriconazole oral</i>	Tier 3	PA
<b>CMV ANTIVIRALS</b>		
LIVTENCITY	Tier 1	PA
<b>CORONAVIRUS (COVID-19)</b>		
PAXLOVID	Tier 1	
<b>ENDONUCLEASE INHIBITORS</b>		
XOFLUZA ORAL TABLET 20 MG, 40 MG	Tier 2	
XOFLUZA ORAL TABLET 80 MG	Tier 1	
<b>ERYTHROMYCIN ANTIBIOTICS</b>		
E.E.S. 400 ORAL TABLET	Tier 3	PA
E.E.S. GRANULES	Tier 3	PA
ERYPED 200	Tier 3	PA
ERYPED 400	Tier 3	PA
ERY-TAB	Tier 3	PA
ERYTHROCIN (AS STEARATE) ORAL TABLET 250 MG	Tier 2	
<i>erythromycin ethylsuccinate oral suspension for reconstitution 200 mg/5 ml</i>	Tier 2	
<i>erythromycin ethylsuccinate oral suspension for reconstitution 400 mg/5 ml</i>	Tier 3	PA
<i>erythromycin ethylsuccinate oral tablet</i>	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

Drug Name	Tier	Restrictions/Limits
<i>erythromycin oral</i>	Tier 3	PA
<b>GLYCOPEPTIDE ANTIBIOTICS</b>		
FIRVANQ	Tier 2	
VANCOCIN	Tier 3	PA
<i>vancomycin intravenous recon soln 10 gram, 5 gram, 750 mg</i>	Tier 1	
<i>vancomycin oral capsule</i>	Tier 2	
<i>vancomycin oral recon soln</i>	Tier 3	PA
<b>HIV NUCLEOSIDE, NUCLEOTIDE RT INHIBITORS</b>		
<i>lamivudine oral tablet 100 mg</i>	Tier 1	QL (1 tablet per 1 day)
<b>LINCOMYCIN ANTIBIOTICS</b>		
ACANYA TOPICAL GEL WITH PUMP	Tier 3	PA
CLEOCIN VAGINAL CREAM	Tier 3	PA
CLEOCIN VAGINAL SUPPOSITORY	Tier 2	
<i>clindamycin hcl</i>	Tier 1	
CLINDAMYCIN PEDIATRIC	Tier 1	AGE (Max 12 Years)
<i>clindamycin phosphate topical solution</i>	Tier 1	QL (180 ML per 30 dayss)
<i>clindamycin phosphate topical swab</i>	Tier 1	
<i>clindamycin phosphate vaginal</i>	Tier 2	
<i>clindamycin-benzoyl peroxide topical gel</i>	Tier 2	
<i>clindamycin-benzoyl peroxide topical gel with pump 1.2 %(1 % base) -3.75 %</i>	Tier 1	PA
<i>clindamycin-benzoyl peroxide topical gel with pump 1-5 %, 1.2-2.5 %</i>	Tier 2	
CLINDESSE	Tier 2	
NEUAC	Tier 3	PA
NEUAC KIT	Tier 3	PA
ONEXTON	Tier 3	PA
XACIATO	Tier 3	PA; AGE (Min 12 Years)
<b>MONOBACTAM ANTIBIOTICS</b>		
CAYSTON	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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



Drug Name	Tier	Restrictions/Limits
<b>MONOCLONAL ANTIBODY ANTIVIRALS</b>		
BEYFORTUS	Tier 1	PA
SYNAGIS	Tier 1	PA; QL (5 doses per 365 days)
<b>NATURAL PENICILLIN ANTIBIOTICS</b>		
<i>penicillin v potassium</i>	Tier 1	
<b>NEURAMINIDASE INHIBITOR ANTIVIRALS</b>		
<i>oseltamivir oral capsule</i>	Tier 2	QL (14 capsules per 1 Fill)
<i>oseltamivir oral suspension for reconstitution</i>	Tier 2	QL (120 ML per 1 fill)
RELENZA DISKHALER	Tier 2	QL (20 blisters per 1 fill)
TAMIFLU ORAL CAPSULE	Tier 3	PA; QL (14 capsules per 1 fill)
TAMIFLU ORAL SUSPENSION FOR RECONSTITUTION	Tier 3	PA; QL (120 ML per 1 fill)
<b>NITROIMIDAZOLE DERIVATIVE, TRYPANOCIDAL</b>		
<i>benznidazole</i>	Tier 1	PA
<b>NITROIMIDAZOLE DERIVATIVES, MISC</b>		
FLAGYL ORAL CAPSULE	Tier 3	PA
LIKMEZ	Tier 3	PA
<i>metronidazole oral capsule</i>	Tier 3	PA
<i>metronidazole oral tablet</i>	Tier 2	
<i>metronidazole topical cream</i>	Tier 1	
<i>metronidazole topical gel 0.75 %</i>	Tier 1	
<i>metronidazole vaginal gel 0.75 % (37.5mg/5 gram)</i>	Tier 2	
<i>metronidazole vaginal gel 1.3 % (65 mg/5 gram)</i>	Tier 3	PA
NUVESSA	Tier 2	
VANDAZOLE	Tier 3	PA
<b>NUCLEOSIDE AND NUCLEOTIDE ANTIVIRALS</b>		
<i>acyclovir oral</i>	Tier 2	
<i>acyclovir topical cream</i>	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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



<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>acyclovir topical ointment</i>	Tier 2	
<i>adefovir</i>	Tier 1	QL (1 tablet per 1 day)
<i>entecavir</i>	Tier 1	QL (1 tablet per 1 day)
<i>famciclovir</i>	Tier 2	
LAGEVRIO (EUA)	Tier 1	
<i>valacyclovir</i>	Tier 2	
<i>valganciclovir oral tablet</i>	Tier 1	QL (2 tablets per 1 day)
VALTREX	Tier 3	PA
VEMLIDY	Tier 1	PA; QL (30 tablets per 30 dayss); AGE (Min 12 Years)
XERESE	Tier 3	PA
ZOVIRAX ORAL SUSPENSION	Tier 3	PA
ZOVIRAX TOPICAL CREAM	Tier 2	
ZOVIRAX TOPICAL OINTMENT	Tier 3	PA
<b>OTHER MACROLIDE ANTIBIOTICS</b>		
<i>amoxicil-clarithromy-lansopraz</i>	Tier 3	PA; QL (224 capsules per 1 fill)
<i>azithromycin oral packet</i>	Tier 2	QL (2 packets per 1 fill)
<i>azithromycin oral suspension for reconstitution</i>	Tier 2	
<i>azithromycin oral tablet 250 mg</i>	Tier 2	
<i>azithromycin oral tablet 500 mg</i>	Tier 2	QL (3 tablets per 1 fill)
<i>azithromycin oral tablet 600 mg</i>	Tier 2	QL (12 tablets per 1 fill)
<i>clarithromycin oral suspension for reconstitution</i>	Tier 2	
<i>clarithromycin oral tablet</i>	Tier 2	QL (28 tablets per 1 fill)
<i>clarithromycin oral tablet extended release 24 hr</i>	Tier 3	PA
DIFICID	Tier 2	
OMECLAMOX-PAK	Tier 3	PA
ZITHROMAX ORAL PACKET	Tier 3	PA; QL (2 packets per 1 fill)
ZITHROMAX ORAL SUSPENSION FOR RECONSTITUTION	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

Drug Name	Tier	Restrictions/Limits
ZITHROMAX ORAL TABLET 250 MG	Tier 3	PA
ZITHROMAX ORAL TABLET 500 MG	Tier 3	PA; QL (3 tablets per 1 fill)
ZITHROMAX TRI-PAK	Tier 3	PA; QL (3 tablets per 1 fill)
ZITHROMAX Z-PAK	Tier 3	PA
<b>OTHER MISC. ANTIBACTERIAL AGENTS</b>		
<i>bismuth subcit k-metronidz-tcn</i>	Tier 3	PA
PYLERA	Tier 2	
<b>OXAZOLIDINONE ANTIBIOTICS</b>		
<i>linezolid oral suspension for reconstitution</i>	Tier 3	PA
<i>linezolid oral tablet</i>	Tier 2	QL (28 tablets per 1 fill)
SIVEXTRO ORAL	Tier 3	PA; QL (14 tablets per 1 fill)
ZYVOX ORAL SUSPENSION FOR RECONSTITUTION	Tier 3	PA
ZYVOX ORAL TABLET	Tier 3	PA; QL (28 tablets per 1 fill)
<b>PENICILLINASE-RESISTANT PENICILLINS</b>		
<i>dicloxacillin</i>	Tier 1	
<b>POLYENE ANTIFUNGALS</b>		
<i>nystatin oral</i>	Tier 2	
<b>POLYMYXIN ANTIBIOTICS</b>		
<i>polymyxin b sulf-trimethoprim</i>	Tier 1	
<b>PYRIMIDINE ANTIFUNGALS</b>		
ANCOBON	Tier 3	PA
<i>flucytosine</i>	Tier 3	PA
<b>QUINOLONE ANTIBIOTICS</b>		
BAXDELA ORAL	Tier 3	PA
CILOXAN OPHTHALMIC (EYE) OINTMENT	Tier 3	PA
CIPRO HC	Tier 3	PA
CIPRO ORAL SUSPENSION, MICROCAPSULE RECON	Tier 2	
CIPRO ORAL TABLET 250 MG, 500 MG	Tier 3	PA; QL (42 tablets per 1 fill)
<i>ciprofloxacin</i>	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>ciprofloxacin hcl ophthalmic (eye)</i>	Tier 2	
<i>ciprofloxacin hcl oral</i>	Tier 2	QL (42 tablets per 1 fill)
<i>ciprofloxacin hcl otic (ear)</i>	Tier 3	PA
<i>ciprofloxacin-dexamethasone</i>	Tier 3	PA
<i>ciprofloxacin-fluocinolone</i>	Tier 3	PA
<i>levofloxacin oral solution</i>	Tier 2	
<i>levofloxacin oral tablet 250 mg, 500 mg</i>	Tier 2	QL (14 tablets per 1 fill)
<i>levofloxacin oral tablet 750 mg</i>	Tier 2	QL (28 tablets per 1 fill)
OCUFLOX	Tier 3	PA
<i>ofloxacin ophthalmic (eye)</i>	Tier 2	
<i>ofloxacin oral tablet 300 mg, 400 mg</i>	Tier 3	PA
<i>ofloxacin otic (ear)</i>	Tier 2	
<b>RIFAMYCIN ANTIBIOTICS</b>		
AEMCOLO	Tier 3	PA; QL (12 tablets per 3 days); AGE (Min 18 Years)
PRIFTIN	Tier 1	QL (24 tablets per 28 days)
<i>rifabutin</i>	Tier 1	
<i>rifampin oral</i>	Tier 1	
TALICIA	Tier 3	PA
XIFAXAN ORAL TABLET 200 MG	Tier 3	PA; QL (9 tablets per 1 fill); AGE (Min 12 Years)
XIFAXAN ORAL TABLET 550 MG	Tier 3	PA; AGE (Min 18 Years)
<b>SULFONAMIDE ANTIBIOTICS (SYSTEMIC)</b>		
AZULFIDINE	Tier 3	PA
AZULFIDINE EN-TABS	Tier 3	PA
<i>sulfamethoxazole-trimethoprim oral</i>	Tier 1	
<i>sulfasalazine</i>	Tier 2	
SULFATRIM	Tier 1	
<b>TETRACYCLINE ANTIBIOTICS</b>		
<i>bismuth subcit k-metronidz-tcn</i>	Tier 3	PA
<i>doxycycline hyclate oral capsule</i>	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>doxycycline hyclate oral tablet 100 mg</i>	Tier 1	
<i>doxycycline monohydrate oral capsule 100 mg, 50 mg</i>	Tier 1	
<i>doxycycline monohydrate oral suspension for reconstitution</i>	Tier 1	
<i>doxycycline monohydrate oral tablet 100 mg, 50 mg</i>	Tier 1	
<i>minocycline oral capsule</i>	Tier 1	
PYLERA	Tier 2	
<b>TRITERPENOIDS</b>		
BREXAFEMME	Tier 3	PA; QL (4 tablets per 1 fill)
<b>URINARY ANTI-INFECTIVES</b>		
<i>methenamine hippurate</i>	Tier 1	
<i>methenamine mandelate</i>	Tier 1	
<i>nitrofurantoin macrocrystal oral capsule 100 mg, 50 mg</i>	Tier 1	QL (2 capsules per 1 day); AGE (Max 64 Years)
<i>nitrofurantoin monohyd/m-cryst</i>	Tier 1	QL (2 capsules per 1 day); AGE (Max 64 Years)
<i>trimethoprim</i>	Tier 1	
<b>ANTINEOPLASTIC AGENTS</b>		
<b>ANTINEOPLASTIC AGENTS</b>		
<i>abiraterone</i>	Tier 1	
AFINITOR DISPERZ	Tier 1	
AKEEGA	Tier 1	
ALIMTA	Tier 1	
ALKERAN	Tier 1	
<i>anastrozole</i>	Tier 1	
BESREMI	Tier 1	
<i>bexarotene</i>	Tier 1	
<i>bicalutamide</i>	Tier 1	
BLINCYTO INTRAVENOUS KIT	Tier 1	
BRAFTOVI	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
CAMCEVI (6 MONTH)	Tier 1	
<i>capecitabine</i>	Tier 1	
<i>cyclophosphamide oral capsule</i>	Tier 1	
DAURISMO	Tier 1	
<i>diclofenac sodium topical gel 3 %</i>	Tier 1	
DROXIA	Tier 1	
EMCYT	Tier 1	
ERIVEDGE	Tier 1	
ERLEADA ORAL TABLET 60 MG	Tier 1	
<i>etoposide oral</i>	Tier 1	
<i>everolimus (antineoplastic) oral tablet</i>	Tier 1	
<i>exemestane</i>	Tier 1	
<i>fluorouracil topical cream</i>	Tier 1	
HYCANTIN ORAL	Tier 1	
<i>hydroxyurea</i>	Tier 1	
IDHIFA	Tier 1	
INQOVI	Tier 1	
JAKAFI	Tier 1	
JYLAMVO	Tier 1	
KISQALI FEMARA CO-PACK	Tier 1	
KRAZATI	Tier 1	
<i>lenalidomide oral capsule 10 mg, 15 mg, 25 mg, 5 mg</i>	Tier 1	
<i>letrozole</i>	Tier 1	
LEUKERAN	Tier 1	
<i>leuprolide (3 month)</i>	Tier 1	
<i>leuprolide subcutaneous kit</i>	Tier 1	
LONSURF	Tier 1	
LOQTORZI	Tier 1	
LUMAKRAS ORAL TABLET 120 MG	Tier 1	
LYSODREN	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
MATULANE	Tier 1	
MAVENCLAD (10 TABLET PACK)	Tier 3	PA
MAVENCLAD (4 TABLET PACK)	Tier 3	PA
MAVENCLAD (5 TABLET PACK)	Tier 3	PA
MAVENCLAD (6 TABLET PACK)	Tier 3	PA
MAVENCLAD (7 TABLET PACK)	Tier 3	PA
MAVENCLAD (8 TABLET PACK)	Tier 3	PA
MAVENCLAD (9 TABLET PACK)	Tier 3	PA
<i>megestrol oral suspension 400 mg/10 ml (10 ml), 400 mg/10 ml (40 mg/ml), 800 mg/20 ml (20 ml)</i>	Tier 2	
<i>megestrol oral suspension 625 mg/5 ml (125 mg/ml)</i>	Tier 3	PA
<i>megestrol oral tablet</i>	Tier 1	
<i>melphalan</i>	Tier 1	
<i>mercaptopurine</i>	Tier 1	
<i>methotrexate sodium</i>	Tier 1	
<i>methotrexate sodium (pf) injection solution</i>	Tier 1	
MYLERAN	Tier 1	
<i>nelarabine</i>	Tier 1	
<i>nilutamide</i>	Tier 1	
NUBEQA	Tier 1	
ODOMZO	Tier 1	
ONUREG	Tier 1	
ORGOVYX	Tier 1	
ORSERDU	Tier 1	
<i>pemetrexed disodium intravenous recon soln 100 mg, 500 mg</i>	Tier 1	
POMALYST	Tier 1	
REZLIDHIA	Tier 1	
RIABNI	Tier 1	
SIKLOS	Tier 1	PA; AGE (Min 2 Years)

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
TABLOID	Tier 1	
<i>tamoxifen</i>	Tier 1	
TARGRETIN TOPICAL	Tier 1	
TAZVERIK	Tier 1	
<i>temozolomide</i>	Tier 1	
TIBSOVO	Tier 1	
<i>toremifene</i>	Tier 1	
<i>tretinoin (antineoplastic)</i>	Tier 1	
VENCLEXTA	Tier 1	
VENCLEXTA STARTING PACK	Tier 1	
XATMEP	Tier 1	
XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40 MG/WEEK (40 MG X 1), 60 MG/WEEK (60 MG X 1), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (40 MG X 2), 80MG TWICE WEEK (160 MG/WEEK)	Tier 1	
XTANDI	Tier 1	
ZOLINZA	Tier 1	
ZYTIGA ORAL TABLET 500 MG	Tier 1	
<b>ANTITOXINS, IMMUNE GLOB, TOXOIDS, VACCINES</b>		
<b>ALLERGENIC EXTRACTS (THERAPEUTIC)</b>		
PALFORZIA (LEVEL 1)	Tier 1	PA; AGE (Min 4 Years and Max 17 Years)
PALFORZIA (LEVEL 2)	Tier 1	PA; AGE (Min 4 Years and Max 17 Years)
PALFORZIA (LEVEL 3)	Tier 1	PA; AGE (Min 4 Years and Max 17 Years)
PALFORZIA (LEVEL 4)	Tier 1	PA; AGE (Min 4 Years and Max 17 Years)
PALFORZIA (LEVEL 5)	Tier 1	PA; AGE (Min 4 Years and Max 17 Years)

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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



<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
PALFORZIA (LEVEL 6)	Tier 1	PA; AGE (Min 4 Years and Max 17 Years)
PALFORZIA (LEVEL 7)	Tier 1	PA; AGE (Min 4 Years and Max 17 Years)
PALFORZIA (LEVEL 8)	Tier 1	PA; AGE (Min 4 Years and Max 17 Years)
PALFORZIA (LEVEL 9)	Tier 1	PA; AGE (Min 4 Years and Max 17 Years)
PALFORZIA (LEVEL 10)	Tier 1	PA; AGE (Min 4 Years and Max 17 Years)
PALFORZIA (LEVEL 11 UP-DOSE)	Tier 1	PA; AGE (Min 4 Years and Max 17 Years)
PALFORZIA INITIAL DOSE	Tier 1	PA; AGE (Min 4 Years and Max 17 Years)
PALFORZIA LEVEL 11 MAINTENANCE	Tier 1	PA; AGE (Min 4 Years and Max 17 Years)
<b>TOXOIDS</b>		
ADACEL(TDAP ADOLESN/ADULT)(PF) INTRAMUSCULAR SYRINGE	Tier 1	QL (1 fill per 5 years); AGE (Min 10 Years and Max 64 Years)
TDVAX	Tier 1	
TENIVAC (PF)	Tier 1	
<b>VACCINES</b>		
AFLURIA QD 2023-24(3YR UP)(PF)	Tier 1	
AFLURIA QUAD 2023-2024(6MO UP)	Tier 1	
BEXSERO	Tier 1	
ENGERIX-B (PF)	Tier 1	
ENGERIX-B PEDIATRIC (PF)	Tier 1	
FLUAD QUAD 2023-24(65Y UP)(PF)	Tier 1	
FLUARIX QUAD 2023-2024 (PF)	Tier 1	
FLUBLOK QUAD 2023-2024 (PF)	Tier 1	
FLUCELVAX QUAD 2023-2024	Tier 1	
FLUCELVAX QUAD 2023-2024 (PF)	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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



Drug Name	Tier	Restrictions/Limits
FLULAVAL QUAD 2023-2024 (PF)	Tier 1	
FLUMIST QUAD 2023-2024	Tier 1	
FLUZONE HIGHDOSE QUAD 23-24 PF	Tier 1	
FLUZONE QUAD 2023-2024	Tier 1	
FLUZONE QUAD 2023-2024 (PF)	Tier 1	
GARDASIL 9 (PF)	Tier 1	
HAVRIX (PF)	Tier 1	QL (2 syringes per 1 lifetime); AGE (Min 19 Years)
MENVEO A-C-Y-W-135-DIP (PF)	Tier 1	
M-M-R II (PF)	Tier 1	
MODERNA COVID 23-24(6M-11Y)PF	Tier 1	
PNEUMOVAX-23	Tier 1	
PREHEVBRIO (PF)	Tier 1	
PREVNAR 13 (PF)	Tier 1	
PREVNAR 20 (PF)	Tier 1	
RECOMBIVAX HB (PF)	Tier 1	
SHINGRIX (PF)	Tier 1	AGE (Min 50 Years)
SPIKEVAX 2023-2024(12Y UP)(PF)	Tier 1	
TRUMENBA	Tier 1	
TWINRIX (PF)	Tier 1	
VAQTA (PF) INTRAMUSCULAR SUSPENSION	Tier 1	QL (2 ML per 1 lifetime); AGE (Min 19 Years)
VAQTA (PF) INTRAMUSCULAR SYRINGE	Tier 1	QL (2 syringes per 1 lifetime); AGE (Min 19 Years)
VARIVAX (PF)	Tier 1	
VAXNEUVANCE (PF)	Tier 1	
<b>AUTONOMIC DRUGS</b>		
<b>ALPHA- AND BETA-ADRENERGIC AGONISTS</b>		
AUVI-Q	Tier 3	PA; QL (4 injectors per 1 Fill)
<i>epinephrine injection auto-injector</i>	Tier 2	QL (4 injectors per 1 fill)
EPIPEN	Tier 2	QL (4 injectors per 1 fill)

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
EPIPEN 2-PAK	Tier 2	QL (4 injectors per 1 fill)
EPIPEN JR	Tier 2	QL (4 injectors per 1 fill)
EPIPEN JR 2-PAK	Tier 2	QL (4 injectors per 1 fill)
SYMJEPI	Tier 3	PA
<b>ALPHA-ADRENERGIC AGONISTS</b>		
<i>clonidine</i>	Tier 2	QL (4 patches per 28 days)
<i>clonidine hcl oral tablet</i>	Tier 2	
<i>clonidine hcl oral tablet extended release 24 hr</i>	Tier 2	
LUCEMYRA	Tier 1	QL (224 EA per 14 days)
<i>methyldopa</i>	Tier 2	
<i>methyldopa-hydrochlorothiazide</i>	Tier 3	PA
<i>midodrine</i>	Tier 1	QL (3 tablets per 1 day)
NEXICLON XR	Tier 2	
<b>ANTIMUSCARINICS/ANTISPASMODICS</b>		
ANORO ELLIPTA	Tier 2	QL (3 inhalers per 90 days)
ATROVENT HFA	Tier 2	QL (2 inhalers per 30 days)
BEVESPI AEROSPHERE	Tier 2	QL (3 inhalers per 90 days)
COMBIVENT RESPIMAT	Tier 2	QL (5 inhalers per 90 days)
<i>dicyclomine oral capsule</i>	Tier 1	AGE (Max 64 Years)
<i>dicyclomine oral solution</i>	Tier 1	AGE (Max 64 Years)
<i>dicyclomine oral tablet</i>	Tier 1	AGE (Max 64 Years)
<i>diphenoxylate-atropine</i>	Tier 2	
DUAKLIR PRESSAIR	Tier 3	PA
<i>glycopyrrolate oral solution</i>	Tier 1	AGE (Max 12 Years)
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	Tier 1	
<i>hyoscyamine sulfate oral</i>	Tier 1	AGE (Max 64 Years)
<i>hyoscyamine sulfate sublingual</i>	Tier 1	AGE (Max 64 Years)
INCRUSE ELLIPTA	Tier 2	QL (3 inhalers per 90 days)
<i>ipratropium bromide inhalation</i>	Tier 2	
<i>ipratropium-albuterol</i>	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
SPIRIVA RESPIMAT	Tier 2	QL (1 inhaler per 30 days)
SPIRIVA WITH HANDIHALER	Tier 2	QL (1 capsule per 1 day)
STIOLTO RESPIMAT	Tier 2	QL (3 inhalers per 90 days)
<i>tiotropium bromide</i>	Tier 3	QL (1 capsule per 1 day)
TUDORZA PRESSAIR	Tier 3	PA
YUPELRI	Tier 3	PA
<b>ANTIPARKINSONIAN AGENTS</b>		
<i>amantadine hcl oral capsule</i>	Tier 2	
<i>amantadine hcl oral solution</i>	Tier 2	
<i>amantadine hcl oral tablet</i>	Tier 3	PA
GOCOVRI	Tier 3	PA
OSMOLEX ER	Tier 3	PA
<b>AUTONOMIC DRUGS, MISCELLANEOUS</b>		
TYRVAYA	Tier 3	QL (8.4 ML per 30 days)
<b>CENTRALLY ACTING SKELETAL MUSCLE RELAXNT</b>		
AMRIX	Tier 3	PA
<i>chlorzoxazone</i>	Tier 3	PA
<i>cyclobenzaprine oral capsule, extended release 24hr</i>	Tier 3	PA
<i>cyclobenzaprine oral tablet</i>	Tier 2	
FEXMID	Tier 3	PA
LORZONE	Tier 3	PA
<i>metaxalone</i>	Tier 3	PA
<i>methocarbamol oral tablet 500 mg, 750 mg</i>	Tier 2	
<i>tizanidine oral capsule</i>	Tier 3	PA
<i>tizanidine oral tablet</i>	Tier 2	
ZANAFLEX	Tier 3	PA
<b>DIRECT-ACTING SKELETAL MUSCLE RELAXANTS</b>		
DANTRIUM ORAL CAPSULE 25 MG	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>dantrolene oral</i>	Tier 3	PA
<b>GABA-DERIVATIVE SKELETAL MUSCLE RELAXANT</b>		
<i>baclofen oral solution 5 mg/5 ml</i>	Tier 3	
<i>baclofen oral suspension</i>	Tier 3	PA
<i>baclofen oral tablet 10 mg, 20 mg, 5 mg</i>	Tier 2	
FLEQSUVY	Tier 3	PA
<b>INDIRECT-ACTING SKELETAL MUSCLE RELAXANT</b>		
<i>orphenadrine citrate oral</i>	Tier 2	
<b>NON-SEL. BETA-ADRENERGIC BLOCKING AGENTS</b>		
BETAPACE AF	Tier 3	PA
BETAPACE ORAL TABLET 120 MG, 160 MG, 80 MG	Tier 3	PA
BYSTOLIC	Tier 2	
<i>carvedilol</i>	Tier 2	
<i>carvedilol phosphate</i>	Tier 2	PA
COREG	Tier 3	PA
COREG CR	Tier 3	PA
HEMANGEOL	Tier 3	PA
INDERAL LA	Tier 3	PA
INDERAL XL	Tier 3	PA
INNOPRAN XL	Tier 3	PA
<i>labetalol oral</i>	Tier 2	
<i>nebivolol</i>	Tier 2	PA
<i>pindolol</i>	Tier 3	PA
<i>propranolol oral</i>	Tier 2	
<i>propranolol-hydrochlorothiazid</i>	Tier 3	PA
SOTALOL AF	Tier 2	
<i>sotalol oral</i>	Tier 2	
SOTYLIZE	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>timolol maleate oral</i>	Tier 3	PA
<b>NON-SEL.ALPHA-1-ADRENERGIC BLOCKING AGTS</b>		
CARDURA	Tier 3	PA
CARDURA XL	Tier 3	PA
<i>doxazosin</i>	Tier 2	
<i>prazosin</i>	Tier 2	
<i>terazosin</i>	Tier 2	
<b>PARASYMPATHOMIMETIC (CHOLINERGIC AGENTS)</b>		
ADLARITY	Tier 3	PA
ARICEPT	Tier 3	PA
<i>bethanechol chloride</i>	Tier 1	QL (4 tablets per 1 day)
<i>donepezil oral tablet 10 mg, 5 mg</i>	Tier 2	
<i>donepezil oral tablet 23 mg</i>	Tier 3	PA
<i>donepezil oral tablet, disintegrating</i>	Tier 2	
EXELON PATCH	Tier 2	
<i>galantamine oral capsule, ext rel. pellets 24 hr</i>	Tier 3	PA
<i>galantamine oral solution</i>	Tier 3	PA
<i>galantamine oral tablet</i>	Tier 2	
NAMZARIC	Tier 3	PA
<i>pilocarpine hcl oral</i>	Tier 1	
<i>pyridostigmine bromide oral tablet 60 mg</i>	Tier 1	
<i>rivastigmine</i>	Tier 3	PA
<i>rivastigmine tartrate</i>	Tier 2	
<b>SELECTIVE ALPHA-1-ADRENERGIC BLOCK.AGENT</b>		
<i>alfuzosin</i>	Tier 2	
<i>carvedilol</i>	Tier 2	
<i>carvedilol phosphate</i>	Tier 2	PA
COREG	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

Drug Name	Tier	Restrictions/Limits
COREG CR	Tier 3	PA
<i>dutasteride-tamsulosin</i>	Tier 3	PA
FLOMAX	Tier 3	PA
<i>labetalol oral</i>	Tier 2	
RAPAFLO	Tier 3	PA
<i>silodosin</i>	Tier 3	PA
<i>tamsulosin</i>	Tier 2	
<b>SELECTIVE BETA-2-ADRENERGIC AGONISTS</b>		
ADVAIR DISKUS	Tier 2	QL (3 Inhalers per 90 days)
ADVAIR HFA	Tier 2	QL (1 inhaler per 30 days)
AIRDUO DIGIHALER	Tier 3	PA; QL (1 inhaler per 30 days)
AIRDUO RESPICLICK	Tier 3	PA; QL (1 inhaler per 30 days)
AIRSUPRA	Tier 3	PA
<i>albuterol sulfate inhalation hfa aerosol inhaler</i>	Tier 3	QL (2 inhalers per 30 days)
<i>albuterol sulfate inhalation solution for nebulization</i>	Tier 2	
ANORO ELLIPTA	Tier 2	QL (3 inhalers per 90 days)
<i>arformoterol</i>	Tier 3	PA
BEVESPI AEROSPHERE	Tier 2	QL (3 inhalers per 90 days)
BREO ELLIPTA INHALATION BLISTER WITH DEVICE 100-25 MCG/DOSE, 200-25 MCG/DOSE	Tier 3	PA; QL (60 blisters per 30 days)
BREO ELLIPTA INHALATION BLISTER WITH DEVICE 50-25 MCG/DOSE	Tier 3	PA; QL (60 EA per 30 days)
BREYNA	Tier 3	PA
BROVANA	Tier 3	PA
<i>budesonide-formoterol</i>	Tier 3	PA; QL (2 inhalers per 30 days)
COMBIVENT RESPIMAT	Tier 2	QL (5 inhalers per 90 days)
DUAKLIR PRESSAIR	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
DULERA INHALATION HFA AEROSOL INHALER 100-5 MCG/ACTUATION, 50-5 MCG/ACTUATION	Tier 2	QL (3 inhalers per 90 days)
DULERA INHALATION HFA AEROSOL INHALER 200-5 MCG/ACTUATION	Tier 2	QL (3 Inhalers per 90 days)
<i>fluticasone furoate-vilanterol</i>	Tier 3	PA; QL (60 blisters per 30 days)
<i>fluticasone propion-salmeterol inhalation aerosol powdr breath activated</i>	Tier 3	PA; QL (1 inhaler per 30 dayss)
<i>fluticasone propion-salmeterol inhalation blister with device</i>	Tier 3	PA; QL (60 blisters per 30 dayss)
<i>fluticasone propion-salmeterol inhalation hfa aerosol inhaler</i>	Tier 3	PA; QL (1 inhaler per 30 days)
<i>formoterol fumarate</i>	Tier 3	PA
<i>ipratropium-albuterol</i>	Tier 2	
<i>levalbuterol hcl</i>	Tier 3	PA
<i>levalbuterol tartrate</i>	Tier 3	PA; QL (2 inhalers per 30 days)
PERFOROMIST	Tier 3	PA
PROAIR DIGIHALER	Tier 3	PA; QL (1 inhaler per 30 days)
PROAIR RESPICLICK	Tier 3	PA; QL (1 inhaler per 30 days)
SEREVENT DISKUS	Tier 2	QL (1 inhaler per 30 days)
STIOLTO RESPIMAT	Tier 2	QL (3 inhalers per 90 days)
STRIVERDI RESPIMAT	Tier 3	PA
SYMBICORT	Tier 2	QL (2 inhalers per 30 days)
<i>terbutaline oral</i>	Tier 1	
VENTOLIN HFA	Tier 2	QL (2 inhalers per 30 days)
WIXELA INHUB	Tier 3	PA; QL (60 blisters per 30 days)
XOPENEX HFA	Tier 2	QL (6 inhalers per 90 days)
<b>SELECTIVE BETA-ADRENERGIC BLOCKING AGENT</b>		
<i>acebutolol</i>	Tier 3	PA
<i>atenolol</i>	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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



<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>atenolol-chlorthalidone</i>	Tier 2	
<i>betaxolol oral</i>	Tier 3	PA
<i>bisoprolol fumarate</i>	Tier 3	PA
<i>bisoprolol-hydrochlorothiazide</i>	Tier 2	
KAPSPARGO SPRINKLE	Tier 3	PA
LOPRESSOR ORAL	Tier 3	PA
<i>metoprolol succinate</i>	Tier 2	
<i>metoprolol ta-hydrochlorothiaz</i>	Tier 3	PA
<i>metoprolol tartrate oral</i>	Tier 2	
TENORETIC 100	Tier 3	PA
TENORETIC 50	Tier 3	PA
TENORMIN	Tier 3	PA
TOPROL XL	Tier 3	PA
<b>SKELETAL MUSCLE RELAXANTS, MISCELLANEOUS</b>		
NORGESIC	Tier 3	PA
NORGESIC FORTE	Tier 3	PA
<i>orphenadrine-asa-caffeine oral tablet 25-385-30 mg</i>	Tier 3	PA
<b>SMOKING CESSATION AGENTS</b>		
CHANTIX CONTINUING MONTH BOX	Tier 1	QL (2 tablets per 1 day)
<i>nicotine (polacrilex) buccal gum</i>	Tier 1	QL (306 pieces per 34 days)
<i>nicotine (polacrilex) buccal lozenge</i>	Tier 1	QL (306 lozenges per 34 days)
<i>nicotine (polacrilex) buccal mini lozenge</i>	Tier 1	QL (306 lozenges per 34 days)
<i>nicotine transdermal patch 24 hour</i>	Tier 1	QL (1 patch per 1 day)
<i>nicotine transdermal patch, td daily, sequential</i>	Tier 1	QL (56 patches per 56 days)
NICOTROL NS	Tier 1	QL (40 ML per 30 days)
<i>varenicline</i>	Tier 1	QL (2 tablets per 1 day)

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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



Drug Name	Tier	Restrictions/Limits
<b>BLOOD FORMATION, COAGULATION, THROMBOSIS</b>		
<b>ANTIANEMIA DRUGS</b>		
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML	Tier 2	PA
ARANESP (IN POLYSORBATE) INJECTION SYRINGE	Tier 2	PA
JESDUVROQ	Tier 3	PA
<b>BLOOD FORM.,COAG,THROMBOSIS AGENTS MISC.</b>		
OXBRYTA ORAL TABLET 300 MG	Tier 1	PA; QL (90 tablets per 30 days); AGE (Min 4 Years)
OXBRYTA ORAL TABLET 500 MG	Tier 1	PA; QL (90 tablets per 30 days); AGE (Min 12 Years)
OXBRYTA ORAL TABLET FOR SUSPENSION	Tier 1	PA; QL (90 tablets per 30 days); AGE (Min 4 Years)
<b>COUMARIN DERIVATIVES</b>		
JANTOVEN	Tier 2	
<i>warfarin</i>	Tier 2	
<b>DIRECT FACTOR XA INHIBITORS</b>		
ELIQUIS DVT-PE TREAT 30D START	Tier 2	QL (74 tablets per 30 days)
ELIQUIS ORAL TABLET 2.5 MG	Tier 2	QL (2 tablets per 1 day)
ELIQUIS ORAL TABLET 5 MG	Tier 2	QL (218 tablets per 102 days)
SAVAYSA	Tier 3	PA
XARELTO DVT-PE TREAT 30D START	Tier 2	QL (51 tablets per 30 days)
XARELTO ORAL SUSPENSION FOR RECONSTITUTION	Tier 2	QL (20 ML per 1 day)
XARELTO ORAL TABLET 10 MG, 20 MG	Tier 2	QL (1 tablet per 1 day)
XARELTO ORAL TABLET 15 MG	Tier 2	QL (102 tablets per 102 days)
XARELTO ORAL TABLET 2.5 MG	Tier 2	QL (2 tablets per 1 day)

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

Drug Name	Tier	Restrictions/Limits
<b>DIRECT THROMBIN INHIBITORS</b>		
<i>dabigatran etexilate oral capsule 150 mg, 75 mg</i>	Tier 3	PA; QL (2 capsules per 1 day)
PRADAXA ORAL CAPSULE 110 MG	Tier 2	QL (4 capsules per 1 day)
PRADAXA ORAL CAPSULE 150 MG, 75 MG	Tier 2	QL (2 capsules per 1 day)
PRADAXA ORAL PELLETS IN PACKET	Tier 3	PA; AGE (Max 11 Years)
<b>HEMATOPOIETIC AGENTS</b>		
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML	Tier 2	PA
ARANESP (IN POLYSORBATE) INJECTION SYRINGE	Tier 2	PA
EPOGEN INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	Tier 2	PA
FULPHILA	Tier 3	PA; QL (1 syringe per 14 days)
FYLNETRA	Tier 3	PA; QL (0.6 ML per 14 days)
GRANIX	Tier 3	PA
JESDUVROQ	Tier 3	PA
LEUKINE INJECTION RECON SOLN	Tier 3	PA
NEULASTA	Tier 3	PA; QL (1 syringe per 14 days)
NEULASTA ONPRO	Tier 3	PA; QL (1 syringe per 14 days)
NEUPOGEN	Tier 2	
NIVESTYM	Tier 3	PA
NYVEPRIA	Tier 2	QL (0.6 ML per 14 days)
PROCRIT	Tier 3	PA
RELEUKO SUBCUTANEOUS	Tier 3	PA
RETACRIT	Tier 2	PA
STIMUFEND	Tier 3	PA; QL (0.6 ML per 14 days)
UDENYCA	Tier 3	PA; QL (1 syringe per 14 days)
UDENYCA AUTOINJECTOR	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
ZARXIO	Tier 3	PA; QL (45 ML per 30 dayss)
ZIEXTENZO	Tier 3	PA; QL (1 syringe per 14 days)
<b>HEMORRHEOLOGIC AGENTS</b>		
<i>pentoxifylline</i>	Tier 1	
<b>HEMOSTATICS</b>		
<i>desmopressin nasal spray,non-aerosol 10 mcg/spray (0.1 ml)</i>	Tier 1	PA
<i>desmopressin oral</i>	Tier 1	QL (6 tablets per 1 day)
<b>HEPARINS</b>		
<i>enoxaparin</i>	Tier 2	
FRAGMIN SUBCUTANEOUS SOLUTION 2,500 ANTI-XA UNIT/ML	Tier 3	
FRAGMIN SUBCUTANEOUS SOLUTION 25,000 ANTI-XA UNIT/ML	Tier 3	PA
FRAGMIN SUBCUTANEOUS SYRINGE	Tier 3	PA
<i>heparin (porcine) injection solution 10,000 unit/ml, 5,000 unit/ml</i>	Tier 1	
LOVENOX	Tier 3	PA
<b>INDIRECT FACTOR XA INHIBITORS</b>		
ARIXTRA	Tier 3	PA
<i>fondaparinux</i>	Tier 3	PA
<b>IRON PREPARATIONS</b>		
A THRU Z ADVANCED FORMULA	Tier 1	
A THRU Z MEN'S ULTIMATE	Tier 1	
A THRU Z SELECT WOMEN'S	Tier 1	
BACMIN	Tier 1	
BIO-35, GLUTEN FREE	Tier 1	
CENTRAL-VITE WOMEN'S MATURE	Tier 1	
CENTRUM CHEWABLES ORAL TABLET,CHEWABLE 8 MG-400 MCG- 10 MCG	Tier 1	
CENTRUM COMPLETE	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

Drug Name	Tier	Restrictions/Limits
CENTRUM MEN	Tier 1	
CENTRUM SILVER WOMEN	Tier 1	
CENTRUM ULTRA MEN'S	Tier 1	
CENTURY	Tier 1	
CERTA PLUS	Tier 1	
CERTAVITE-ANTIOXIDANT	Tier 1	
CLASSIC PRENATAL	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
COMPLETE MULTIVITAMIN-MINERAL ORAL TABLET	Tier 1	
COMPLETENATE	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
DAILY MULTIPLE FOR WOMEN	Tier 1	
DAILY MULTIVITAMIN WITH IRON	Tier 1	
DAILY VITAMIN FORMULA-IRON	Tier 1	
DAILY VITAMIN WITH IRON	Tier 1	
DAILY VITES/IRON	Tier 1	
ESSENTIA	Tier 1	
FE C PLUS	Tier 1	AGE (Max 12 Years)
FEOSOL ORAL TABLET 325 MG (65 MG IRON)	Tier 1	
FERATE	Tier 1	
FERGON ORAL TABLET 240 MG (27 MG IRON)	Tier 1	
FEROSUL	Tier 1	
FERRO-TIME	Tier 1	
<i>ferrous gluconate oral tablet 236 mg (27 mg iron), 240 mg (27 mg iron), 324 mg (37.5 mg iron), 324 mg (38 mg iron)</i>	Tier 1	
<i>ferrous sulfate oral drops</i>	Tier 1	AGE (Max 12 Years)
<i>ferrous sulfate oral liquid</i>	Tier 1	AGE (Max 12 Years)

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>ferrous sulfate oral solution</i>	Tier 1	AGE (Max 12 Years)
<i>ferrous sulfate oral tablet</i>	Tier 1	
<i>ferrous sulfate oral tablet, delayed release (dr/ec)</i>	Tier 1	
FORTAVIT	Tier 1	
FREEDAVITE	Tier 1	
HAIR, SKIN AND NAILS-ARGAN OIL	Tier 1	
HAIR,SKIN AND NAILS ORAL TABLET 1 MG IRON-66.7 MCG-1,000 MCG	Tier 1	
IRON	Tier 1	
IRON (FERROUS SULFATE)	Tier 1	
IRON 100 PLUS	Tier 1	AGE (Max 12 Years)
K-PAX IMMUNE SUPPORT	Tier 1	
MEGA MULTI FOR WOMEN	Tier 1	
MONOCAPS	Tier 1	
MULTI COMPLETE WITH IRON	Tier 1	
MULTI FOR HER ORAL TABLET	Tier 1	
MULTI-DAY WITH IRON	Tier 1	
MULTI-VIT WITH FLUORIDE-IRON	Tier 1	QL (2 ML per 1 day); AGE (Max 12 Years)
<i>multivitamin with iron</i>	Tier 1	
<i>multivit-min-iron fum-folic ac</i>	Tier 1	
NANO VM 1-3	Tier 1	
NANO VM 4-8	Tier 1	
NANOVM 9-18	Tier 1	
NANOVM T-F	Tier 1	
NEPHRON FA	Tier 1	
NESTABS	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

Drug Name	Tier	Restrictions/Limits
NESTABS DHA	Tier 1	QL (2 capsules per 1 day); AGE (Min 12 Years and Max 55 Years)
NEWGEN	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
ONE DAILY CALCIUM/IRON	Tier 1	
ONE DAILY COMPLETE ORAL TABLET 18-0.4 MG	Tier 1	
ONE DAILY FOR WOMEN	Tier 1	
ONE DAILY HEALTHY WEIGHT	Tier 1	
ONE DAILY MAXIMUM	Tier 1	
ONE DAILY MULTI-VIT W-MINERAL ORAL TABLET	Tier 1	
ONE DAILY MULTIVIT-IRON(FOLIC)	Tier 1	
ONE DAILY PLUS IRON	Tier 1	
ONE DAILY WOMEN'S ORAL TABLET 18 MG IRON-400 MCG-450 MG CA	Tier 1	
ONE-A-DAY ENERGY	Tier 1	
ONE-A-DAY TEEN ADVANTAGE	Tier 1	
ONE-A-DAY WEIGHTSMART	Tier 1	
ONE-A-DAY WOMEN'S ACTIVE	Tier 1	
ONE-A-DAY WOMEN'S HEALTHY SKIN	Tier 1	
ONE-A-DAY WOMEN'S PETITES	Tier 1	
OPTISOURCE	Tier 1	
OPURITY MULTIVITAMIN	Tier 1	
PARVLEX	Tier 1	
<i>pnv cmb#95-ferrous fumarate-fa</i>	Tier 1	QL (1 tablet per 1 day)
PRENATABS RX	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

Drug Name	Tier	Restrictions/Limits
PRENATAL COMPLETE	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL FORMULA ORAL TABLET 28 MG IRON- 800 MCG	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL MULTI-DHA(WITH VIT K)	Tier 1	AGE (Min 12 Years and Max 55 Years)
PRENATAL MULTIVITAMINS	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL ORAL TABLET 28 MG IRON-800 MCG	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL PLUS (CALCIUM CARB)	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL TABLET	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL VITAMIN PLUS LOW IRON	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL VITAMIN WITH MINERALS	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PROCERV HP	Tier 1	
PRORENAL	Tier 1	
PRORENAL QD	Tier 1	
QUINTABS-M	Tier 1	
SE-NATAL-19	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
SENTRY	Tier 1	
SIDEROL	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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



Drug Name	Tier	Restrictions/Limits
SLOW RELEASE IRON ORAL TABLET EXTENDED RELEASE 142 MG (45 MG IRON), 160 MG (50 MG IRON), 250 MG (50 MG IRON)	Tier 1	
SPECTRAVITE ADVANCED FORMULA	Tier 1	
SPECTRAVITE MEN'S	Tier 1	
STRESS FORMULA WITH IRON	Tier 1	
STRESS FORMULA WITH IRON(SULF)	Tier 1	
SUNVITE	Tier 1	
TAB-A-VITE MULTIVITAMIN W-IRON ORAL TABLET 15 MG IRON- 400 MCG	Tier 1	
THERA-M ORAL TABLET 27-0.4 MG	Tier 1	
THERANATAL ORAL TABLET	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
THERAPEUTIC-M	Tier 1	
THERATRUM COMPLETE WITH LUTEIN	Tier 1	
TRICARE	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
TRINATAL RX 1	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
ULTRA FREEDA ORAL TABLET 6 MG IRON-267 MCG	Tier 1	
WESTAB PLUS	Tier 1	
WOMEN'S DAILY FORMULA ORAL TABLET 27-0.4 MG	Tier 1	
WOMEN'S ONE DAILY ORAL TABLET 18 MG IRON-400 MCG-500 MG CA	Tier 1	
YELETS	Tier 1	
<b>PLATELET-AGGREGATION INHIBITORS</b>		
ASPIRIN CHILDRENS	Tier 1	QL (1 tablet per 1 day)

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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



Drug Name	Tier	Restrictions/Limits
<i>aspirin oral tablet</i>	Tier 1	QL (1 tablet per 1 day); AGE (Min 40 Years and Max 79 Years)
<i>aspirin oral tablet,chewable</i>	Tier 1	QL (1 tablet per 1 day)
<i>aspirin oral tablet,delayed release (dr/ec) 325 mg</i>	Tier 1	QL (1 tablet per 1 day); AGE (Min 40 Years and Max 79 Years)
<i>aspirin oral tablet,delayed release (dr/ec) 81 mg</i>	Tier 1	QL (1 tablet per 1 day)
<i>aspirin rectal suppository 300 mg</i>	Tier 1	
<i>aspirin,buffd-calcium carb-mag</i>	Tier 1	AGE (Min 40 Years and Max 79 Years)
<i>aspirin-dipyridamole</i>	Tier 3	PA
BAYER ASPIRIN	Tier 1	QL (1 tablet per 1 day); AGE (Min 40 Years and Max 79 Years)
BAYER CHEWABLE ASPIRIN	Tier 1	QL (1 tablet per 1 day)
BAYER LOW DOSE ASPIRIN	Tier 1	QL (1 tablet per 1 day)
BRILINTA	Tier 2	
BUFFERIN	Tier 1	AGE (Min 40 Years and Max 79 Years)
<i>butalbital-aspirin-caffeine oral capsule</i>	Tier 1	QL (4 capsules per 1 day); AGE (Max 64 Years)
CHILDREN'S ASPIRIN	Tier 1	QL (1 tablet per 1 day)
<i>cilostazol</i>	Tier 1	QL (2 tablets per 1 day)
<i>clopidogrel oral tablet 300 mg</i>	Tier 2	QL (2 tablets per 30 days)
<i>clopidogrel oral tablet 75 mg</i>	Tier 2	QL (1 tablet per 1 day)
<i>dipyridamole oral</i>	Tier 3	PA
ECOTRIN LOW STRENGTH	Tier 1	QL (1 tablet per 1 day)
EFFIENT	Tier 3	PA; AGE (Max 75 Years)
PLAVIX ORAL TABLET 75 MG	Tier 3	PA; QL (1 tablet per 1 day)
<i>prasugrel</i>	Tier 2	AGE (Max 75 Years)

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

Drug Name	Tier	Restrictions/Limits
TRI-BUFFERED ASPIRIN	Tier 1	AGE (Min 40 Years and Max 79 Years)
YOSPRALA	Tier 3	PA
<b>PLATELET-REDUCING AGENTS</b>		
<i>anagrelide</i>	Tier 1	
<b>THROMBOLYTIC AGENTS</b>		
ASPIRIN CHILDRENS	Tier 1	QL (1 tablet per 1 day)
<i>aspirin oral tablet</i>	Tier 1	QL (1 tablet per 1 day); AGE (Min 40 Years and Max 79 Years)
<i>aspirin oral tablet,chewable</i>	Tier 1	QL (1 tablet per 1 day)
<i>aspirin oral tablet,delayed release (dr/ec) 325 mg</i>	Tier 1	QL (1 tablet per 1 day); AGE (Min 40 Years and Max 79 Years)
<i>aspirin oral tablet,delayed release (dr/ec) 81 mg</i>	Tier 1	QL (1 tablet per 1 day)
<i>aspirin rectal suppository 300 mg</i>	Tier 1	
<i>aspirin,buffd-calcium carb-mag</i>	Tier 1	AGE (Min 40 Years and Max 79 Years)
BAYER ASPIRIN	Tier 1	QL (1 tablet per 1 day); AGE (Min 40 Years and Max 79 Years)
BAYER CHEWABLE ASPIRIN	Tier 1	QL (1 tablet per 1 day)
BAYER LOW DOSE ASPIRIN	Tier 1	QL (1 tablet per 1 day)
BUFFERIN	Tier 1	AGE (Min 40 Years and Max 79 Years)
<i>butalbital-aspirin-caffeine oral capsule</i>	Tier 1	QL (4 capsules per 1 day); AGE (Max 64 Years)
CHILDREN'S ASPIRIN	Tier 1	QL (1 tablet per 1 day)
ECOTRIN LOW STRENGTH	Tier 1	QL (1 tablet per 1 day)
TRI-BUFFERED ASPIRIN	Tier 1	AGE (Min 40 Years and Max 79 Years)
YOSPRALA	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

Drug Name	Tier	Restrictions/Limits
<b>CARDIOVASCULAR DRUGS</b>		
<b>ACL INHIBITORS</b>		
NEXLETOL	Tier 3	PA; AGE (Min 18 Years)
NEXLIZET	Tier 3	PA; AGE (Min 18 Years)
<b>ALPHA-ADRENERGIC BLOCKING AGENTS</b>		
<i>acebutolol</i>	Tier 3	PA
<i>atenolol</i>	Tier 2	
CARDURA	Tier 3	PA
CARDURA XL	Tier 3	PA
<i>carvedilol</i>	Tier 2	
<i>carvedilol phosphate</i>	Tier 2	PA
COREG	Tier 3	PA
COREG CR	Tier 3	PA
<i>doxazosin</i>	Tier 2	
<i>labetalol oral</i>	Tier 2	
<i>prazosin</i>	Tier 2	
TENORMIN	Tier 3	PA
<i>terazosin</i>	Tier 2	
<b>ALPHA-ADRENERGIC BLOCKING AGT.(HYPOTEN)</b>		
CARDURA	Tier 3	PA
CARDURA XL	Tier 3	PA
<i>doxazosin</i>	Tier 2	
<i>prazosin</i>	Tier 2	
<i>terazosin</i>	Tier 2	
<b>ANGIOTENSIN II RECEPTOR ANTAGONIST/NEPROLYS</b>		
ENTRESTO	Tier 2	QL (60 tablets per 30 days)
<b>ANGIOTENSIN II RECEPTOR ANTAGON.(HYPOTN)</b>		
<i>amlodipine-olmesartan</i>	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>amlodipine-valsartan</i>	Tier 2	
<i>amlodipine-valsartan-hcthiazyd</i>	Tier 2	
ATACAND	Tier 3	PA
ATACAND HCT	Tier 3	PA
AVALIDE	Tier 3	PA
AVAPRO	Tier 3	PA
AZOR	Tier 3	PA
BENICAR	Tier 3	PA
BENICAR HCT	Tier 3	PA
<i>candesartan</i>	Tier 3	PA
<i>candesartan-hydrochlorothiazid</i>	Tier 3	PA
COZAAR	Tier 3	PA
DIOVAN	Tier 3	PA
DIOVAN HCT	Tier 3	PA
EDARBI	Tier 3	PA
EDARBYCLOR	Tier 3	PA
<i>eprosartan</i>	Tier 3	PA
EXFORGE	Tier 3	PA
EXFORGE HCT	Tier 3	PA
HYZAAR	Tier 3	PA
<i>irbesartan</i>	Tier 3	PA
<i>irbesartan-hydrochlorothiazide</i>	Tier 3	PA
<i>losartan</i>	Tier 2	
<i>losartan-hydrochlorothiazide</i>	Tier 2	
MICARDIS	Tier 3	PA
MICARDIS HCT	Tier 3	PA
<i>olmesartan</i>	Tier 2	
<i>olmesartan-amlodipin-hcthiazyd</i>	Tier 3	PA
<i>olmesartan-hydrochlorothiazide</i>	Tier 2	
<i>telmisartan</i>	Tier 3	PA
<i>telmisartan-amlodipine</i>	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>telmisartan-hydrochlorothiazid</i>	Tier 3	PA
TRIBENZOR	Tier 3	PA
<i>valsartan oral solution</i>	Tier 3	PA
<i>valsartan oral tablet</i>	Tier 2	
<i>valsartan-hydrochlorothiazide</i>	Tier 2	
<b>ANGIOTENSIN II RECEPTOR ANTAGONISTS</b>		
<i>amlodipine-olmesartan</i>	Tier 2	
<i>amlodipine-valsartan</i>	Tier 2	
<i>amlodipine-valsartan-hcthiazyd</i>	Tier 2	
ATACAND	Tier 3	PA
ATACAND HCT	Tier 3	PA
AVALIDE	Tier 3	PA
AVAPRO	Tier 3	PA
AZOR	Tier 3	PA
BENICAR	Tier 3	PA
BENICAR HCT	Tier 3	PA
<i>candesartan</i>	Tier 3	PA
<i>candesartan-hydrochlorothiazid</i>	Tier 3	PA
COZAAR	Tier 3	PA
DIOVAN	Tier 3	PA
DIOVAN HCT	Tier 3	PA
EDARBI	Tier 3	PA
EDARBYCLOR	Tier 3	PA
<i>eprosartan</i>	Tier 3	PA
EXFORGE	Tier 3	PA
EXFORGE HCT	Tier 3	PA
HYZAAR	Tier 3	PA
<i>irbesartan</i>	Tier 3	PA
<i>irbesartan-hydrochlorothiazide</i>	Tier 3	PA
<i>losartan</i>	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>losartan-hydrochlorothiazide</i>	Tier 2	
MICARDIS	Tier 3	PA
MICARDIS HCT	Tier 3	PA
<i>olmesartan</i>	Tier 2	
<i>olmesartan-amlodipin-hcthiazid</i>	Tier 3	PA
<i>olmesartan-hydrochlorothiazide</i>	Tier 2	
<i>telmisartan</i>	Tier 3	PA
<i>telmisartan-amlodipine</i>	Tier 3	PA
<i>telmisartan-hydrochlorothiazid</i>	Tier 3	PA
TRIBENZOR	Tier 3	PA
<i>valsartan oral solution</i>	Tier 3	PA
<i>valsartan oral tablet</i>	Tier 2	
<i>valsartan-hydrochlorothiazide</i>	Tier 2	
<b>ANGIOTENSIN-CONVERT.ENZYME INHIB(HYPOTN)</b>		
ACCUPRIL	Tier 3	PA
ACCURETIC ORAL TABLET 20-25 MG	Tier 3	PA
ALTACE	Tier 3	PA
<i>amlodipine-benazepril</i>	Tier 2	
<i>benazepril</i>	Tier 2	
<i>benazepril-hydrochlorothiazide</i>	Tier 2	
<i>captopril</i>	Tier 3	PA
<i>captopril-hydrochlorothiazide</i>	Tier 3	PA
<i>enalapril maleate oral solution</i>	Tier 3	PA
<i>enalapril maleate oral tablet</i>	Tier 2	
<i>enalapril-hydrochlorothiazide</i>	Tier 2	
EPANED	Tier 3	PA
<i>fosinopril</i>	Tier 3	PA
<i>fosinopril-hydrochlorothiazide</i>	Tier 3	PA
<i>lisinopril</i>	Tier 2	
<i>lisinopril-hydrochlorothiazide</i>	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
LOTENSIN HCT	Tier 3	PA
LOTENSIN ORAL TABLET 10 MG, 20 MG, 40 MG	Tier 3	PA
LOTREL	Tier 3	PA
<i>moexipril</i>	Tier 3	PA
<i>perindopril erbumine</i>	Tier 3	PA
QBRELIS	Tier 3	PA
<i>quinapril</i>	Tier 3	PA
<i>quinapril-hydrochlorothiazide</i>	Tier 3	PA
<i>ramipril</i>	Tier 2	
<i>trandolapril</i>	Tier 3	PA
<i>trandolapril-verapamil</i>	Tier 3	PA
VASERETIC	Tier 3	PA
VASOTEC	Tier 3	PA
ZESTORETIC	Tier 3	PA
ZESTRIL	Tier 3	PA
<b>ANGIOTENSIN-CONVERTING ENZYME INHIBITORS</b>		
ACCUPRIL	Tier 3	PA
ACCURETIC ORAL TABLET 20-25 MG	Tier 3	PA
ALTACE	Tier 3	PA
<i>amlodipine-benazepril</i>	Tier 2	
<i>benazepril</i>	Tier 2	
<i>benazepril-hydrochlorothiazide</i>	Tier 2	
<i>captopril</i>	Tier 3	PA
<i>captopril-hydrochlorothiazide</i>	Tier 3	PA
<i>enalapril maleate oral solution</i>	Tier 3	PA
<i>enalapril maleate oral tablet</i>	Tier 2	
<i>enalapril-hydrochlorothiazide</i>	Tier 2	
EPANED	Tier 3	PA
<i>fosinopril</i>	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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



<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>fosinopril-hydrochlorothiazide</i>	Tier 3	PA
<i>lisinopril</i>	Tier 2	
<i>lisinopril-hydrochlorothiazide</i>	Tier 2	
LOTENSIN HCT	Tier 3	PA
LOTENSIN ORAL TABLET 10 MG, 20 MG, 40 MG	Tier 3	PA
LOTREL	Tier 3	PA
<i>moexipril</i>	Tier 3	PA
<i>perindopril erbumine</i>	Tier 3	PA
QBRELIS	Tier 3	PA
<i>quinapril</i>	Tier 3	PA
<i>quinapril-hydrochlorothiazide</i>	Tier 3	PA
<i>ramipril</i>	Tier 2	
<i>trandolapril</i>	Tier 3	PA
<i>trandolapril-verapamil</i>	Tier 3	PA
VASERETIC	Tier 3	PA
VASOTEC	Tier 3	PA
ZESTORETIC	Tier 3	PA
ZESTRIL	Tier 3	PA
<b>ANTIARRHYTHMICS, MISCELLANEOUS</b>		
<i>magnesium sulfate in d5w intravenous piggyback 1 gram/100 ml</i>	Tier 1	
<i>magnesium sulfate in water</i>	Tier 1	
<i>magnesium sulfate injection</i>	Tier 1	
<b>ANTILIPEMIC AGENTS, MISCELLANEOUS</b>		
ENDUR-ACIN ORAL TABLET EXTENDED RELEASE 250 MG	Tier 1	
FISH OIL ORAL CAPSULE 100-160-1,000 MG, 300-1,000 MG, 300-500 MG, 360-1,200 MG, 60-90-500 MG	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

Drug Name	Tier	Restrictions/Limits
FISH OIL ORAL CAPSULE, DELAYED RELEASE (DR/EC) 300-1,000 MG, 360-1,200 MG	Tier 1	
<i>niacin (inositol niacinate) oral capsule 400 mg niacin (500 mg), 500 mg</i>	Tier 1	
<i>niacin (inositol niacinate) oral tablet</i>	Tier 1	
NIACIN FLUSH FREE	Tier 1	
NIACIN NO FLUSH	Tier 1	
<i>niacin oral capsule, extended release 500 mg</i>	Tier 2	
<i>niacin oral tablet 100 mg, 500 mg</i>	Tier 2	
<i>niacin oral tablet 250 mg, 50 mg</i>	Tier 1	
<i>niacin oral tablet extended release 1,000 mg, 250 mg</i>	Tier 1	
<i>niacin oral tablet extended release 24 hr</i>	Tier 3	PA
<i>niacin oral tablet extended release 500 mg</i>	Tier 2	
<i>omega 3-dha-epa-fish oil oral capsule 1,000 mg (120 mg-180 mg), 1,200 (144-216) mg, 300-1,000 mg</i>	Tier 1	
<i>omega 3-dha-epa-fish oil oral capsule, delayed release (dr/ec) 300 mg (120 mg- 180mg)-1,000 mg, 300-1,000 mg</i>	Tier 1	
<i>omega-3 fatty acids</i>	Tier 1	
<i>omega-3 fatty acids-fish oil oral capsule 300-1,000 mg, 360-1,200 mg</i>	Tier 1	
SLO-NIACIN ORAL TABLET EXTENDED RELEASE 250 MG, 750 MG	Tier 1	
SMART HEART OMEGA-3	Tier 1	
SUPER OMEGA-3	Tier 1	
<b>BETA-ADRENERGIC BLOCKING AGENTS</b>		
<i>atenolol-chlorthalidone</i>	Tier 2	
BETAPACE AF	Tier 3	PA
BETAPACE ORAL TABLET 120 MG, 160 MG, 80 MG	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>betaxolol oral</i>	Tier 3	PA
<i>bisoprolol fumarate</i>	Tier 3	PA
<i>bisoprolol-hydrochlorothiazide</i>	Tier 2	
BYSTOLIC	Tier 2	
CORGARD	Tier 3	PA
HEMANGEOL	Tier 3	PA
INDERAL LA	Tier 3	PA
INDERAL XL	Tier 3	PA
INNOPRAN XL	Tier 3	PA
KAPSPARGO SPRINKLE	Tier 3	PA
<i>labetalol oral</i>	Tier 2	
LOPRESSOR ORAL	Tier 3	PA
<i>metoprolol succinate</i>	Tier 2	
<i>metoprolol ta-hydrochlorothiaz</i>	Tier 3	PA
<i>metoprolol tartrate oral</i>	Tier 2	
<i>nadolol</i>	Tier 3	PA
<i>nebivolol</i>	Tier 2	PA
<i>pindolol</i>	Tier 3	PA
<i>propranolol oral</i>	Tier 2	
<i>propranolol-hydrochlorothiazid</i>	Tier 3	PA
SOTALOL AF	Tier 2	
<i>sotalol oral</i>	Tier 2	
SOTYLIZE	Tier 3	PA
TENORETIC 100	Tier 3	PA
TENORETIC 50	Tier 3	PA
<i>timolol maleate oral</i>	Tier 3	PA
TOPROL XL	Tier 3	PA
<b>BETA-ADRENERGIC BLOCKING AGT.(HYPOTEN)</b>		
<i>atenolol-chlorthalidone</i>	Tier 2	
BETAPACE AF	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
BETAPACE ORAL TABLET 120 MG, 160 MG, 80 MG	Tier 3	PA
<i>bisoprolol-hydrochlorothiazide</i>	Tier 2	
CORGARD	Tier 3	PA
HEMANGEOL	Tier 3	PA
INDERAL LA	Tier 3	PA
INDERAL XL	Tier 3	PA
INNOPRAN XL	Tier 3	PA
KAPSPARGO SPRINKLE	Tier 3	PA
<i>labetalol oral</i>	Tier 2	
LOPRESSOR ORAL	Tier 3	PA
<i>metoprolol succinate</i>	Tier 2	
<i>metoprolol ta-hydrochlorothiaz</i>	Tier 3	PA
<i>metoprolol tartrate oral</i>	Tier 2	
<i>nadolol</i>	Tier 3	PA
<i>pindolol</i>	Tier 3	PA
<i>propranolol oral</i>	Tier 2	
<i>propranolol-hydrochlorothiazid</i>	Tier 3	PA
SOTALOL AF	Tier 2	
<i>sotalol oral</i>	Tier 2	
SOTYLIZE	Tier 3	PA
TENORETIC 100	Tier 3	PA
TENORETIC 50	Tier 3	PA
<i>timolol maleate oral</i>	Tier 3	PA
TOPROL XL	Tier 3	PA
<b>BILE ACID SEQUESTRANTS</b>		
<i>cholestyramine (with sugar)</i>	Tier 2	
CHOLESTYRAMINE LIGHT	Tier 2	
<i>cholestyramine-aspartame</i>	Tier 2	
<i>colesevelam</i>	Tier 3	PA
COLESTID ORAL GRANULES	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
COLESTID ORAL TABLET	Tier 3	PA
<i>colestipol oral granules</i>	Tier 3	PA
<i>colestipol oral packet</i>	Tier 3	PA
<i>colestipol oral tablet</i>	Tier 2	
PREVALITE	Tier 2	
QUESTRAN	Tier 3	PA
QUESTRAN LIGHT	Tier 3	PA
WELCHOL	Tier 3	PA
<b>CALCIUM-CHANNEL BLOCK.AGT,MISC(HYPOTEN)</b>		
<i>trandolapril-verapamil</i>	Tier 3	PA
<b>CALCIUM-CHANNEL BLOCKING AGENTS</b>		
<i>amlodipine</i>	Tier 2	
<i>amlodipine-atorvastatin</i>	Tier 3	PA; QL (1 tablet per 1 day)
<i>amlodipine-benazepril</i>	Tier 2	
<i>amlodipine-olmesartan</i>	Tier 2	
<i>amlodipine-valsartan</i>	Tier 2	
<i>amlodipine-valsartan-hcthiazyd</i>	Tier 2	
AZOR	Tier 3	PA
CADUET	Tier 3	PA; QL (1 tablet per 1 day)
CARDIZEM CD	Tier 3	PA
CARDIZEM LA	Tier 3	PA
CARDIZEM ORAL TABLET 120 MG, 30 MG, 60 MG	Tier 3	PA
CARTIA XT	Tier 2	
<i>diltiazem hcl oral capsule,extended release 12 hr</i>	Tier 2	
<i>diltiazem hcl oral capsule,extended release 24 hr</i>	Tier 2	
<i>diltiazem hcl oral capsule,extended release 24hr</i>	Tier 2	
<i>diltiazem hcl oral tablet</i>	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>diltiazem hcl oral tablet extended release 24 hr</i>	Tier 3	PA
DILT-XR	Tier 2	
EXFORGE	Tier 3	PA
EXFORGE HCT	Tier 3	PA
<i>felodipine</i>	Tier 3	PA
<i>isradipine</i>	Tier 3	PA
KATERZIA	Tier 3	PA; AGE (Min 6 Years)
<i>levamlodipine</i>	Tier 3	PA
LOTREL	Tier 3	PA
MATZIM LA	Tier 3	PA
<i>nicardipine oral</i>	Tier 3	PA
<i>nifedipine</i>	Tier 2	
<i>nimodipine</i>	Tier 1	QL (252 capsules per 1 year)
<i>nisoldipine</i>	Tier 3	PA
NORLIQVA	Tier 3	PA; AGE (Min 6 Years)
NORVASC	Tier 3	PA
<i>olmesartan-amlodipin-hcthiaazid</i>	Tier 3	PA
PROCARDIA XL	Tier 3	PA
SULAR ORAL TABLET EXTENDED RELEASE 24 HR 17 MG, 34 MG, 8.5 MG	Tier 3	PA
TAZTIA XT	Tier 2	
<i>telmisartan-amlodipine</i>	Tier 3	PA
TIADYLT ER	Tier 3	PA
TIAZAC	Tier 3	PA
<i>trandolapril-verapamil</i>	Tier 3	PA
TRIBENZOR	Tier 3	PA
<i>verapamil oral capsule, 24 hr er pellet ct</i>	Tier 3	PA
<i>verapamil oral capsule,ext rel. pellets 24 hr</i>	Tier 3	PA
<i>verapamil oral tablet</i>	Tier 2	
<i>verapamil oral tablet extended release</i>	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
VERELAN PM	Tier 3	PA
<b>CALCIUM-CHANNEL BLOCKING AGENTS, MISC.</b>		
<i>trandolapril-verapamil</i>	Tier 3	PA
<b>CARBONIC ANHYDRASE INHIBITORS (24:36)</b>		
<i>acetazolamide oral capsule, extended release</i>	Tier 1	QL (2 capsules per 1 day)
<i>acetazolamide oral tablet</i>	Tier 1	QL (4 tablets per 1 day)
<b>CARDIAC DRUGS, MISCELLANEOUS</b>		
<i>ranolazine</i>	Tier 1	PA; QL (2 tablets per 1 day)
VYNDAMAX	Tier 1	PA; QL (1 capsule per 1 day); AGE (Min 18 Years)
VYNDAQEL	Tier 1	PA; QL (4 capsules per 1 day); AGE (Min 18 Years)
<b>CARDIOTONIC AGENTS</b>		
CORLANOR	Tier 1	PA
<i>digoxin oral tablet 125 mcg (0.125 mg), 250 mcg (0.25 mg)</i>	Tier 1	
<b>CARDIOVASCULAR DRUGS, NSAID ANTI-INFL</b>		
<i>colchicine oral capsule</i>	Tier 3	PA
<i>colchicine oral tablet</i>	Tier 2	
COLCRYS	Tier 3	PA
GLOPERBA	Tier 3	PA
MITIGARE	Tier 3	PA
<b>CENTRAL ALPHA-AGONISTS</b>		
<i>clonidine</i>	Tier 2	QL (4 patches per 28 days)
<i>clonidine hcl oral tablet</i>	Tier 2	
<i>clonidine hcl oral tablet extended release 24 hr</i>	Tier 2	
<i>guanfacine oral tablet</i>	Tier 2	
<i>methyldopa</i>	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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



Drug Name	Tier	Restrictions/Limits
<i>methyldopa-hydrochlorothiazide</i>	Tier 3	PA
NEXICLON XR	Tier 2	
<b>CGMP SYNTHESIS AGENT</b>		
VERQUVO	Tier 1	PA; QL (1 tablet per 1 day); AGE (Min 18 Years)
<b>CHOLESTEROL ABSORPTION INHIBITORS</b>		
<i>ezetimibe</i>	Tier 2	
<i>ezetimibe-simvastatin</i>	Tier 3	PA; QL (1 tablet per 1 day)
VYTORIN 10-10	Tier 3	PA; QL (1 tablet per 1 day)
VYTORIN 10-20	Tier 3	PA; QL (1 tablet per 1 day)
VYTORIN 10-40	Tier 3	PA; QL (1 tablet per 1 day)
VYTORIN 10-80	Tier 3	PA; QL (1 tablet per 1 day)
ZETIA	Tier 3	PA
<b>CLASS IA ANTIARRHYTHMICS</b>		
<i>disopyramide phosphate oral capsule</i>	Tier 1	AGE (Max 64 Years)
<i>quinidine sulfate oral tablet</i>	Tier 1	
<b>CLASS IB ANTIARRHYTHMICS</b>		
<i>mexiletine</i>	Tier 1	
<b>CLASS IC ANTIARRHYTHMICS</b>		
<i>flecainide</i>	Tier 1	
<i>propafenone oral tablet</i>	Tier 1	
<b>CLASS II ANTIARRHYTHMICS</b>		
<i>acebutolol</i>	Tier 3	PA
<i>atenolol</i>	Tier 2	
<i>atenolol-chlorthalidone</i>	Tier 2	
BETAPACE AF	Tier 3	PA
BETAPACE ORAL TABLET 120 MG, 160 MG, 80 MG	Tier 3	PA
<i>betaxolol oral</i>	Tier 3	PA
<i>bisoprolol fumarate</i>	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>bisoprolol-hydrochlorothiazide</i>	Tier 2	
<i>carvedilol</i>	Tier 2	
<i>carvedilol phosphate</i>	Tier 2	PA
COREG	Tier 3	PA
COREG CR	Tier 3	PA
CORGARD	Tier 3	PA
HEMANGEOL	Tier 3	PA
INDERAL LA	Tier 3	PA
INDERAL XL	Tier 3	PA
INNOPRAN XL	Tier 3	PA
KAPSPARGO SPRINKLE	Tier 3	PA
<i>labetalol oral</i>	Tier 2	
LOPRESSOR ORAL	Tier 3	PA
<i>metoprolol succinate</i>	Tier 2	
<i>metoprolol ta-hydrochlorothiaz</i>	Tier 3	PA
<i>metoprolol tartrate oral</i>	Tier 2	
<i>nadolol</i>	Tier 3	PA
<i>pindolol</i>	Tier 3	PA
<i>propranolol oral</i>	Tier 2	
<i>propranolol-hydrochlorothiazid</i>	Tier 3	PA
SOTALOL AF	Tier 2	
<i>sotalol oral</i>	Tier 2	
SOTYLIZE	Tier 3	PA
TENORETIC 100	Tier 3	PA
TENORETIC 50	Tier 3	PA
TENORMIN	Tier 3	PA
<i>timolol maleate oral</i>	Tier 3	PA
TOPROL XL	Tier 3	PA
<b>CLASS III ANTIARRHYTHMICS</b>		
<i>amiodarone oral tablet 100 mg</i>	Tier 1	QL (1 tablet per 1 day)
<i>amiodarone oral tablet 200 mg, 400 mg</i>	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

Drug Name	Tier	Restrictions/Limits
BETAPACE AF	Tier 3	PA
BETAPACE ORAL TABLET 120 MG, 160 MG, 80 MG	Tier 3	PA
SOTALOL AF	Tier 2	
<i>sotalol oral</i>	Tier 2	
SOTYLIZE	Tier 3	PA
<b>CLASS IV ANTIARRHYTHMICS</b>		
CARDIZEM CD	Tier 3	PA
CARDIZEM LA	Tier 3	PA
CARDIZEM ORAL TABLET 120 MG, 30 MG, 60 MG	Tier 3	PA
CARTIA XT	Tier 2	
<i>diltiazem hcl oral capsule, extended release 12 hr</i>	Tier 2	
<i>diltiazem hcl oral capsule, extended release 24 hr</i>	Tier 2	
<i>diltiazem hcl oral capsule, extended release 24hr</i>	Tier 2	
<i>diltiazem hcl oral tablet</i>	Tier 2	
<i>diltiazem hcl oral tablet extended release 24 hr</i>	Tier 3	PA
DILT-XR	Tier 2	
MATZIM LA	Tier 3	PA
TAZTIA XT	Tier 2	
TIADYLT ER	Tier 3	PA
TIAZAC	Tier 3	PA
<i>verapamil oral capsule, 24 hr er pellet ct</i>	Tier 3	PA
<i>verapamil oral capsule, ext rel. pellets 24 hr</i>	Tier 3	PA
<i>verapamil oral tablet</i>	Tier 2	
<i>verapamil oral tablet extended release</i>	Tier 2	
VERELAN PM	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

Drug Name	Tier	Restrictions/Limits
<b>DIHYDROPYRIDINES</b>		
<i>amlodipine</i>	Tier 2	
<i>amlodipine-atorvastatin</i>	Tier 3	PA; QL (1 tablet per 1 day)
<i>amlodipine-benazepril</i>	Tier 2	
<i>amlodipine-olmesartan</i>	Tier 2	
<i>amlodipine-valsartan</i>	Tier 2	
<i>amlodipine-valsartan-hcthiazid</i>	Tier 2	
AZOR	Tier 3	PA
CADUET	Tier 3	PA; QL (1 tablet per 1 day)
EXFORGE	Tier 3	PA
EXFORGE HCT	Tier 3	PA
<i>felodipine</i>	Tier 3	PA
<i>isradipine</i>	Tier 3	PA
KATERZIA	Tier 3	PA; AGE (Min 6 Years)
<i>levamlodipine</i>	Tier 3	PA
LOTREL	Tier 3	PA
<i>nicardipine oral</i>	Tier 3	PA
<i>nifedipine</i>	Tier 2	
<i>nimodipine</i>	Tier 1	QL (252 capsules per 1 year)
<i>nisoldipine</i>	Tier 3	PA
NORLIQVA	Tier 3	PA; AGE (Min 6 Years)
NORVASC	Tier 3	PA
<i>olmesartan-amlodipin-hcthiazid</i>	Tier 3	PA
PROCARDIA XL	Tier 3	PA
SULAR ORAL TABLET EXTENDED RELEASE 24 HR 17 MG, 34 MG, 8.5 MG	Tier 3	PA
<i>telmisartan-amlodipine</i>	Tier 3	PA
TRIBENZOR	Tier 3	PA
<b>DIHYDROPYRIDINES (ANTIHYPERTENSIVE)</b>		
<i>amlodipine</i>	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>amlodipine-atorvastatin</i>	Tier 3	PA; QL (1 tablet per 1 day)
<i>amlodipine-benazepril</i>	Tier 2	
<i>amlodipine-olmesartan</i>	Tier 2	
<i>amlodipine-valsartan</i>	Tier 2	
<i>amlodipine-valsartan-hcthiazyd</i>	Tier 2	
AZOR	Tier 3	PA
CADUET	Tier 3	PA; QL (1 tablet per 1 day)
EXFORGE	Tier 3	PA
EXFORGE HCT	Tier 3	PA
<i>felodipine</i>	Tier 3	PA
<i>isradipine</i>	Tier 3	PA
KATERZIA	Tier 3	PA; AGE (Min 6 Years)
<i>levamlodipine</i>	Tier 3	PA
LOTREL	Tier 3	PA
<i>nicardipine oral</i>	Tier 3	PA
<i>nifedipine</i>	Tier 2	
<i>nimodipine</i>	Tier 1	QL (252 capsules per 1 year)
<i>nisoldipine</i>	Tier 3	PA
NORLIQVA	Tier 3	PA; AGE (Min 6 Years)
NORVASC	Tier 3	PA
<i>olmesartan-amlodipin-hcthiazyd</i>	Tier 3	PA
PROCARDIA XL	Tier 3	PA
SULAR ORAL TABLET EXTENDED RELEASE 24 HR 17 MG, 34 MG, 8.5 MG	Tier 3	PA
<i>telmisartan-amlodipine</i>	Tier 3	PA
TRIBENZOR	Tier 3	PA
<b>DIRECT VASODILATORS</b>		
<i>hydralazine injection</i>	Tier 1	
<i>hydralazine oral tablet 10 mg, 25 mg, 50 mg</i>	Tier 1	QL (4 tablets per 1 day)
<i>hydralazine oral tablet 100 mg</i>	Tier 1	QL (3 tablets per 1 day)
<i>minoxidil oral</i>	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

Drug Name	Tier	Restrictions/Limits
<b>DIURETICS, MISCELLANEOUS (24:36)</b>		
<i>theophylline oral elixir</i>	Tier 1	
<i>theophylline oral solution</i>	Tier 1	
<i>theophylline oral tablet extended release 12 hr 300 mg, 450 mg</i>	Tier 1	
<i>theophylline oral tablet extended release 24 hr</i>	Tier 1	
<b>FIBRIC ACID DERIVATIVES</b>		
<i>fenofibrate micronized oral capsule 130 mg, 43 mg, 90 mg</i>	Tier 3	PA
<i>fenofibrate micronized oral capsule 134 mg, 200 mg, 67 mg</i>	Tier 2	
<i>fenofibrate nanocrystallized</i>	Tier 2	
<i>fenofibrate oral capsule</i>	Tier 3	PA
<i>fenofibrate oral tablet 120 mg, 40 mg</i>	Tier 3	PA
<i>fenofibrate oral tablet 160 mg, 54 mg</i>	Tier 2	
<i>fenofibric acid (choline)</i>	Tier 3	PA
<i>fenofibric acid oral tablet 105 mg</i>	Tier 3	PA
<i>fenofibric acid oral tablet 35 mg</i>	Tier 1	
FENOGLIDE	Tier 3	PA
<i>gemfibrozil</i>	Tier 2	
LIPOFEN	Tier 3	PA
LOPID	Tier 3	PA
TRICOR	Tier 3	PA
TRILIPIX	Tier 3	PA
<b>HMG-COA REDUCTASE INHIBITORS</b>		
ALTOPREV	Tier 3	PA; QL (1 tablet per 1 day)
<i>amlodipine-atorvastatin</i>	Tier 3	PA; QL (1 tablet per 1 day)
ATORVALIQ	Tier 3	PA; QL (20 ML per 1 day)
<i>atorvastatin</i>	Tier 2	QL (1 tablet per 1 day)
CADUET	Tier 3	PA; QL (1 tablet per 1 day)
EZALLOR SPRINKLE	Tier 3	PA; QL (1 capsule per 1 day)

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>ezetimibe-simvastatin</i>	Tier 3	PA; QL (1 tablet per 1 day)
<i>fluvastatin oral capsule 20 mg</i>	Tier 3	PA; QL (1 tablet per 1 day)
<i>fluvastatin oral capsule 40 mg</i>	Tier 3	PA; QL (1 capsule per 1 day)
<i>fluvastatin oral tablet extended release 24 hr</i>	Tier 3	PA; QL (1 tablet per 1 day)
LESCOL XL	Tier 3	PA; QL (1 tablet per 1 day)
LIPITOR	Tier 3	PA; QL (1 tablet per 1 day)
LIVALO	Tier 3	PA; QL (1 tablet per 1 day)
<i>lovastatin</i>	Tier 2	QL (1 tablet per 1 day)
<i>pitavastatin calcium</i>	Tier 3	PA
<i>pravastatin</i>	Tier 2	QL (1 tablet per 1 day)
<i>rosuvastatin</i>	Tier 2	QL (1 tablet per 1 day)
<i>simvastatin</i>	Tier 2	QL (1 tablet per 1 day)
VYTORIN 10-10	Tier 3	PA; QL (1 tablet per 1 day)
VYTORIN 10-20	Tier 3	PA; QL (1 tablet per 1 day)
VYTORIN 10-40	Tier 3	PA; QL (1 tablet per 1 day)
VYTORIN 10-80	Tier 3	PA; QL (1 tablet per 1 day)
ZOCOR ORAL TABLET 10 MG, 20 MG, 40 MG	Tier 3	PA; QL (1 tablet per 1 day)
ZYPITAMAG	Tier 3	PA; QL (1 tablet per 1 day)
<b>HYPOTENSIVE AGENTS, MISCELLANEOUS</b>		
<i>amlodipine</i>	Tier 2	
<i>amlodipine-benazepril</i>	Tier 2	
<i>amlodipine-olmesartan</i>	Tier 2	
<i>amlodipine-valsartan</i>	Tier 2	
AZOR	Tier 3	PA
BETAPACE AF	Tier 3	PA
BETAPACE ORAL TABLET 120 MG, 160 MG, 80 MG	Tier 3	PA
CARDURA	Tier 3	PA
CARDURA XL	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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



<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>doxazosin</i>	Tier 2	
EXFORGE	Tier 3	PA
<i>felodipine</i>	Tier 3	PA
HEMANGEOL	Tier 3	PA
INDERAL LA	Tier 3	PA
INDERAL XL	Tier 3	PA
INNOPRAN XL	Tier 3	PA
<i>isradipine</i>	Tier 3	PA
KATERZIA	Tier 3	PA; AGE (Min 6 Years)
<i>levamlodipine</i>	Tier 3	PA
LOTREL	Tier 3	PA
<i>nicardipine oral</i>	Tier 3	PA
<i>nifedipine</i>	Tier 2	
<i>nimodipine</i>	Tier 1	QL (252 capsules per 1 year)
<i>nisoldipine</i>	Tier 3	PA
NORLIQVA	Tier 3	PA; AGE (Min 6 Years)
NORVASC	Tier 3	PA
<i>pindolol</i>	Tier 3	PA
PROCARDIA XL	Tier 3	PA
<i>propranolol oral</i>	Tier 2	
SOTALOL AF	Tier 2	
<i>sotalol oral</i>	Tier 2	
SOTYLIZE	Tier 3	PA
SULAR ORAL TABLET EXTENDED RELEASE 24 HR 17 MG, 34 MG, 8.5 MG	Tier 3	PA
<i>terazosin</i>	Tier 2	
<i>timolol maleate oral</i>	Tier 3	PA
<b>LOOP DIURETICS (24:36)</b>		
<i>furosemide oral solution 10 mg/ml, 40 mg/5 ml (8 mg/ml)</i>	Tier 1	AGE (Max 12 Years)
<i>furosemide oral tablet</i>	Tier 1	QL (2 tablets per 1 day)

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>torse mide oral tablet 10 mg, 20 mg</i>	Tier 1	QL (4 tablets per 1 day)
<i>torse mide oral tablet 100 mg, 5 mg</i>	Tier 1	QL (2 tablets per 1 day)
<b>MINERALOCORTICOID (ALDOSTERONE) ANTAGNISTS</b>		
KERENDIA	Tier 1	PA; QL (1 tablet per 1 day); AGE (Min 18 Years)
<i>spironolacton-hydrochlorothiaz</i>	Tier 1	QL (3 tablets per 1 day)
<b>MINERALOCORTICOID(ALDOSTER.)ANTAG (HYPOT)</b>		
KERENDIA	Tier 1	PA; QL (1 tablet per 1 day); AGE (Min 18 Years)
<i>spironolactone oral tablet</i>	Tier 1	QL (2 tablets per 1 day)
<i>spironolacton-hydrochlorothiaz</i>	Tier 1	QL (3 tablets per 1 day)
<b>NITRATES AND NITRITES</b>		
<i>isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg</i>	Tier 1	
<i>isosorbide dinitrate oral tablet 40 mg</i>	Tier 2	
<i>isosorbide mononitrate oral tablet</i>	Tier 1	
<i>isosorbide mononitrate oral tablet extended release 24 hr 120 mg, 60 mg</i>	Tier 1	QL (2 tablets per 1 day)
<i>isosorbide mononitrate oral tablet extended release 24 hr 30 mg</i>	Tier 1	QL (1 tablet per 1 day)
NITRO-BID	Tier 1	
<i>nitroglycerin oral</i>	Tier 1	
<i>nitroglycerin sublingual</i>	Tier 1	
<i>nitroglycerin transdermal patch 24 hour</i>	Tier 1	QL (1 patch per 1 day)
<i>nitroglycerin translingual</i>	Tier 1	ST
<b>OMEGA-3-MEDIATED ANTILIPEMICS</b>		
<i>icosapent ethyl oral capsule 1 gram</i>	Tier 3	PA
LOVAZA	Tier 3	PA
<i>omega-3 acid ethyl esters</i>	Tier 3	PA
VASCEPA	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

Drug Name	Tier	Restrictions/Limits
<b>PCSK9 INHIBITORS</b>		
PRALUENT PEN SUBCUTANEOUS PEN INJECTOR 150 MG/ML	Tier 3	PA; QL (2 pens per 28 dayss)
PRALUENT PEN SUBCUTANEOUS PEN INJECTOR 75 MG/ML	Tier 3	PA; QL (2 injectors per 28 dayss)
REPATHA PUSHTRONEX	Tier 2	PA; QL (7 ML per 28 days)
REPATHA SURECLICK	Tier 2	PA; QL (2 injectors per 28 dayss)
REPATHA SYRINGE	Tier 2	PA; QL (2 syringes per 28 dayss)
<b>PHOSPHODIESTERASE TYPE 5 INHIBITORS</b>		
ADCIRCA	Tier 3	PA
ALYQ	Tier 2	PA
ENTADFI	Tier 1	PA
LIQREV	Tier 3	PA
REVATIO ORAL	Tier 3	PA
<i>sildenafil (pulm.hypertension) oral</i>	Tier 2	PA
<i>tadalafil (pulm. hypertension)</i>	Tier 2	PA
TADLIQ	Tier 3	PA; AGE (Min 18 Years)
<b>POTASSIUM-SPARING DIURETIC</b>		
<i>spironolactone oral tablet</i>	Tier 1	QL (2 tablets per 1 day)
<b>POTASSIUM-SPARING DIURETICS (HYPOTEN)</b>		
<i>amiloride</i>	Tier 1	QL (1 tablet per 1 day)
<i>amiloride-hydrochlorothiazide</i>	Tier 1	QL (2 tablets per 1 day)
<i>spironolacton-hydrochlorothiaz</i>	Tier 1	QL (3 tablets per 1 day)
<i>triamterene-hydrochlorothiazid</i>	Tier 1	
<b>RENIN INHIBITORS</b>		
<i>aliskiren</i>	Tier 3	PA
TEKTURNA	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

Drug Name	Tier	Restrictions/Limits
<b>SCLEROSING AGENTS</b>		
<i>carvedilol</i>	Tier 2	
<i>carvedilol phosphate</i>	Tier 2	PA
COREG	Tier 3	PA
COREG CR	Tier 3	PA
<i>labetalol oral</i>	Tier 2	
<b>STEROIDAL MINERALOCORTICOID RECEPTOR ANT</b>		
<i>spironolactone oral tablet</i>	Tier 1	QL (2 tablets per 1 day)
<b>THIAZIDE DIURETICS (24:36)</b>		
ACCURETIC ORAL TABLET 20-25 MG	Tier 3	PA
<i>amiloride-hydrochlorothiazide</i>	Tier 1	QL (2 tablets per 1 day)
<i>amlodipine-valsartan-hcthiazid</i>	Tier 2	
ATACAND HCT	Tier 3	PA
AVALIDE	Tier 3	PA
<i>benazepril-hydrochlorothiazide</i>	Tier 2	
BENICAR HCT	Tier 3	PA
<i>bisoprolol-hydrochlorothiazide</i>	Tier 2	
<i>candesartan-hydrochlorothiazid</i>	Tier 3	PA
<i>captopril-hydrochlorothiazide</i>	Tier 3	PA
DIOVAN HCT	Tier 3	PA
DIURIL	Tier 1	AGE (Max 12 Years)
<i>enalapril-hydrochlorothiazide</i>	Tier 2	
EXFORGE HCT	Tier 3	PA
<i>fosinopril-hydrochlorothiazide</i>	Tier 3	PA
<i>hydrochlorothiazide</i>	Tier 1	
HYZAAR	Tier 3	PA
<i>irbesartan-hydrochlorothiazide</i>	Tier 3	PA
<i>lisinopril-hydrochlorothiazide</i>	Tier 2	
<i>losartan-hydrochlorothiazide</i>	Tier 2	
LOTENSIN HCT	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>methyldopa-hydrochlorothiazide</i>	Tier 3	PA
<i>metoprolol ta-hydrochlorothiaz</i>	Tier 3	PA
MICARDIS HCT	Tier 3	PA
<i>olmesartan-amlodipin-hcthiazid</i>	Tier 3	PA
<i>olmesartan-hydrochlorothiazide</i>	Tier 2	
<i>propranolol-hydrochlorothiazid</i>	Tier 3	PA
<i>quinapril-hydrochlorothiazide</i>	Tier 3	PA
<i>spironolacton-hydrochlorothiaz</i>	Tier 1	QL (3 tablets per 1 day)
<i>telmisartan-hydrochlorothiazid</i>	Tier 3	PA
<i>triamterene-hydrochlorothiazid</i>	Tier 1	
TRIBENZOR	Tier 3	PA
<i>valsartan-hydrochlorothiazide</i>	Tier 2	
VASERETIC	Tier 3	PA
ZESTORETIC	Tier 3	PA
<b>THIAZIDE-LIKE DIURETICS (24:36)</b>		
<i>atenolol-chlorthalidone</i>	Tier 2	
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	Tier 1	QL (4 tablets per 1 day)
EDARBYCLOR	Tier 3	PA
<i>indapamide</i>	Tier 1	QL (1 tablet per 1 day)
<i>metolazone</i>	Tier 1	QL (1 tablet per 1 day)
TENORETIC 100	Tier 3	PA
TENORETIC 50	Tier 3	PA
<b>VASODILATING AGENTS, MISCELLANEOUS</b>		
ADEMPAS	Tier 3	PA
<i>ambrisentan</i>	Tier 2	PA
<i>amlodipine</i>	Tier 2	
<i>amlodipine-atorvastatin</i>	Tier 3	PA; QL (1 tablet per 1 day)
<i>amlodipine-benazepril</i>	Tier 2	
<i>amlodipine-olmesartan</i>	Tier 2	
<i>amlodipine-valsartan</i>	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
AZOR	Tier 3	PA
<i>bosentan</i>	Tier 3	PA
CADUET	Tier 3	PA; QL (1 tablet per 1 day)
EXFORGE	Tier 3	PA
<i>felodipine</i>	Tier 3	PA
<i>isradipine</i>	Tier 3	PA
KATERZIA	Tier 3	PA; AGE (Min 6 Years)
LETAIRIS	Tier 3	PA
<i>levamlodipine</i>	Tier 3	PA
LOTREL	Tier 3	PA
<i>nicardipine oral</i>	Tier 3	PA
<i>nifedipine</i>	Tier 2	
<i>nimodipine</i>	Tier 1	QL (252 capsules per 1 year)
<i>nisoldipine</i>	Tier 3	PA
NORLIQVA	Tier 3	PA; AGE (Min 6 Years)
NORVASC	Tier 3	PA
OPSUMIT	Tier 2	PA
ORENITRAM	Tier 3	PA
ORENITRAM MONTH 1 TITRATION KT	Tier 3	PA
ORENITRAM MONTH 2 TITRATION KT	Tier 3	PA
ORENITRAM MONTH 3 TITRATION KT	Tier 3	PA
PROCARDIA XL	Tier 3	PA
SULAR ORAL TABLET EXTENDED RELEASE 24 HR 17 MG, 34 MG, 8.5 MG	Tier 3	PA
<i>telmisartan-amlodipine</i>	Tier 3	PA
TRACLEER ORAL TABLET	Tier 2	PA
TRACLEER ORAL TABLET FOR SUSPENSION	Tier 3	PA
<i>trandolapril-verapamil</i>	Tier 3	PA
TYVASO	Tier 2	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

Drug Name	Tier	Restrictions/Limits
TYVASO DPI INHALATION CARTRIDGE WITH INHALER 16 MCG, 16 MCG (112)- 32 MCG (84), 16(112)-32(112) -48(28) MCG, 32 MCG, 48 MCG, 64 MCG	Tier 2	PA
TYVASO INSTITUTIONAL START KIT	Tier 2	PA
TYVASO REFILL KIT	Tier 2	PA
TYVASO STARTER KIT	Tier 2	PA
UPTRAVI ORAL	Tier 2	PA
<b>CENTRAL NERVOUS SYSTEM AGENTS</b>		
<b>ADAMANTANES (CNS)</b>		
<i>amantadine hcl oral capsule</i>	Tier 2	
<i>amantadine hcl oral solution</i>	Tier 2	
<i>amantadine hcl oral tablet</i>	Tier 3	PA
GOCOVRI	Tier 3	PA
OSMOLEX ER	Tier 3	PA
<b>ADENOSINE A2A RECEPTOR ANTAGONISTS</b>		
NOURIANZ	Tier 3	PA
<b>AMPHETAMINE DERIVATIVES</b>		
ADIPEX-P ORAL TABLET	Tier 2	PA; AGE (Min 18 Years)
<i>diethylpropion</i>	Tier 2	PA; AGE (Min 18 Years)
LOMAIRA	Tier 2	PA; AGE (Min 18 Years)
<i>phendimetrazine tartrate</i>	Tier 2	PA; AGE (Min 18 Years)
<i>phentermine</i>	Tier 2	PA; AGE (Min 18 Years)
<b>AMPHETAMINES</b>		
<i>benzphetamine</i>	Tier 2	PA; AGE (Min 18 Years)
<b>AMYOTROPHIC LATERAL SCLEROSIS(ALS) AGENT</b>		
EXSERVAN	Tier 1	PA; AGE (Min 18 Years)
RELYVRIO	Tier 1	PA; QL (4 packets per 1 day); AGE (Min 18 Years)
<i>riluzole</i>	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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



Drug Name	Tier	Restrictions/Limits
TIGLUTIK	Tier 1	PA; AGE (Min 18 Years)
<b>ANALGESICS AND ANTIPYRETICS, MISC.</b>		
ACETAMINOPHEN EXTRA STRENGTH	Tier 1	
<i>acetaminophen oral liquid 160 mg/5 ml</i>	Tier 1	QL (3 GM per 1 day)
<i>acetaminophen oral solution 160 mg/5 ml (5 ml)</i>	Tier 1	QL (3 MG per 1 day)
<i>acetaminophen oral suspension 160 mg/5 ml</i>	Tier 1	QL (3 GM per 1 day)
<i>acetaminophen oral tablet</i>	Tier 1	
<i>acetaminophen oral tablet extended release</i>	Tier 1	
<i>acetaminophen oral tablet, disintegrating 160 mg</i>	Tier 1	QL (3 GM per 1 day)
<i>acetaminophen oral tablet, disintegrating 80 mg</i>	Tier 1	
ACETAMINOPHEN PAIN RELIEF	Tier 1	
<i>acetaminophen rectal suppository 120 mg</i>	Tier 1	QL (3 GM per 1 day)
<i>acetaminophen rectal suppository 650 mg</i>	Tier 1	
<i>acetaminophen-caff-dihydrocod</i>	Tier 3	PA
<i>acetaminophen-codeine oral solution 120-12 mg/5 ml</i>	Tier 2	AGE (Min 12 Years)
<i>acetaminophen-codeine oral tablet</i>	Tier 2	AGE (Min 12 Years)
ATHENOL	Tier 1	
BETATEMP	Tier 1	
<i>butalbital-acetaminop-caf-cod</i>	Tier 3	PA; AGE (Min 12 Years)
<i>butalbital-acetaminophen oral tablet 50-325 mg</i>	Tier 1	QL (4 tablets per 1 day); AGE (Min 10 Years and Max 64 Years)
<i>butalbital-acetaminophen-caff oral tablet</i>	Tier 1	QL (4 tablets per 1 day); AGE (Min 10 Years and Max 64 Years)
CHILD FEVER REDUCER-PAIN RELVR	Tier 1	
CHILD PAIN REL-FEVER REDUCER	Tier 1	
CHILDREN'S ACETAMINOPHEN ORAL SUSPENSION	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

Drug Name	Tier	Restrictions/Limits
CHILDREN'S ACETAMINOPHEN ORAL TABLET,CHEWABLE 80 MG	Tier 1	
CHILDREN'S FEVER REDUCING	Tier 1	
CHILDREN'S MAPAP ORAL TABLET,CHEWABLE 80 MG	Tier 1	
CHILDREN'S NON-ASPIRIN	Tier 1	
CHILDREN'S PAIN RELIEF ORAL SUSPENSION	Tier 1	
CHILDREN'S PAIN-FEVER RELIEF ORAL SUSPENSION	Tier 1	
CHILDREN'S TYLENOL ORAL SUSPENSION	Tier 1	
DUAL ACTION PAIN RELIEVER	Tier 3	PA
ENDOCET ORAL TABLET 10-325 MG, 5-325 MG, 7.5-325 MG	Tier 2	
ESGIC ORAL TABLET	Tier 1	QL (4 tablets per 1 day); AGE (Min 10 Years and Max 64 Years)
FEVER REDUCER	Tier 1	
FEVERALL RECTAL SUPPOSITORY 120 MG, 325 MG, 650 MG	Tier 1	
FIORICET WITH CODEINE	Tier 3	PA; AGE (Min 12 Years)
<i>gabapentin oral tablet extended release 24 hr</i>	Tier 2	
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 300 MG	Tier 2	QL (3 EA per 1 day)
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 450 MG, 600 MG, 750 MG, 900 MG	Tier 2	QL (1800 MG per 1 day)
HORIZANT	Tier 2	QL (2 tablets per 1 day)
<i>hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml</i>	Tier 2	
<i>hydrocodone-acetaminophen oral tablet 10-300 mg, 10-325 mg, 5-300 mg, 5-325 mg, 7.5-300 mg, 7.5-325 mg</i>	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

Drug Name	Tier	Restrictions/Limits
INFANT FEVER REDUCER-PAIN RELF	Tier 1	
INFANT PAIN RELIEVER	Tier 1	
INFANTS' PAIN AND FEVER	Tier 1	
INFANTS' PAIN RELIEF	Tier 1	
LITTLE REMEDIES FEVER AND PAIN	Tier 1	
MAPAP (ACETAMINOPHEN) ORAL CAPSULE	Tier 1	
M-PAP	Tier 1	
NON-ASPIRIN	Tier 1	
NON-ASPIRIN EXTRA STRENGTH	Tier 1	
NON-ASPIRIN PAIN RELIEF	Tier 1	
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	Tier 2	
PAIN RELIEF (ACETAMINOPHEN) ORAL LIQUID	Tier 1	
PAIN RELIEF (ACETAMINOPHEN) ORAL TABLET	Tier 1	
PAIN RELIEF ES (ACETAMINOPHEN)	Tier 1	
PAIN RELIEVER (ACETAMINOPHEN) ORAL TABLET 325 MG	Tier 1	
PAIN RELIEVER ES(ACETAMINOPHN)	Tier 1	
PERCOCET	Tier 3	PA
PHARBETOL	Tier 1	
TACTINAL	Tier 1	
TENCON	Tier 1	QL (4 tablets per 1 day); AGE (Min 10 Years and Max 64 Years)
<i>tramadol-acetaminophen</i>	Tier 2	AGE (Min 12 Years)
TYLENOL EXTRA STRENGTH ORAL TABLET	Tier 1	
TYLENOL ORAL TABLET	Tier 1	
<b>ANTICONVULSANTS, MISCELLANEOUS</b>		
HORIZANT	Tier 2	QL (2 tablets per 1 day)

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>magnesium chloride injection</i>	Tier 1	
<i>magnesium sulfate in d5w intravenous piggyback 1 gram/100 ml</i>	Tier 1	
<i>magnesium sulfate in water</i>	Tier 1	
<i>magnesium sulfate injection</i>	Tier 1	
<b>ANTIDEPRESSANTS, MISCELLANEOUS</b>		
<i>bupropion hcl (smoking deter)</i>	Tier 1	QL (2 tablets per 1 day)
<b>ANTIMIGRAINE AGENTS, MISCELLANEOUS</b>		
ASCOMP WITH CODEINE	Tier 3	PA; AGE (Min 12 Years)
ASPIRIN CHILDRENS	Tier 1	QL (1 tablet per 1 day)
<i>aspirin oral tablet</i>	Tier 1	QL (1 tablet per 1 day); AGE (Min 40 Years and Max 79 Years)
<i>aspirin oral tablet, chewable</i>	Tier 1	QL (1 tablet per 1 day)
<i>aspirin oral tablet, delayed release (dr/ec) 325 mg</i>	Tier 1	QL (1 tablet per 1 day); AGE (Min 40 Years and Max 79 Years)
<i>aspirin oral tablet, delayed release (dr/ec) 81 mg</i>	Tier 1	QL (1 tablet per 1 day)
<i>aspirin rectal suppository 300 mg</i>	Tier 1	
<i>aspirin, buffd-calcium carb-mag</i>	Tier 1	AGE (Min 40 Years and Max 79 Years)
BAYER ASPIRIN	Tier 1	QL (1 tablet per 1 day); AGE (Min 40 Years and Max 79 Years)
BAYER CHEWABLE ASPIRIN	Tier 1	QL (1 tablet per 1 day)
BAYER LOW DOSE ASPIRIN	Tier 1	QL (1 tablet per 1 day)
BUFFERIN	Tier 1	AGE (Min 40 Years and Max 79 Years)
<i>butalbital-acetaminop-caf-cod</i>	Tier 3	PA; AGE (Min 12 Years)
<i>butalbital-acetaminophen-caff oral tablet</i>	Tier 1	QL (4 tablets per 1 day); AGE (Min 10 Years and Max 64 Years)

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>butalbital-aspirin-caffeine oral capsule</i>	Tier 1	QL (4 capsules per 1 day); AGE (Max 64 Years)
CHILDREN'S ASPIRIN	Tier 1	QL (1 tablet per 1 day)
<i>codeine-butalbital-asa-caff</i>	Tier 3	PA; AGE (Min 12 Years)
<i>diclofenac potassium oral capsule</i>	Tier 3	PA
<i>diclofenac potassium oral tablet</i>	Tier 3	PA
<i>diclofenac sodium oral tablet extended release 24 hr</i>	Tier 3	PA
<i>diclofenac sodium oral tablet, delayed release (dr/ec)</i>	Tier 2	
ECOTRIN LOW STRENGTH	Tier 1	QL (1 tablet per 1 day)
ESGIC ORAL TABLET	Tier 1	QL (4 tablets per 1 day); AGE (Min 10 Years and Max 64 Years)
FIORICET WITH CODEINE	Tier 3	PA; AGE (Min 12 Years)
HEMANGEOL	Tier 3	PA
INDERAL LA	Tier 3	PA
INDERAL XL	Tier 3	PA
INNOPRAN XL	Tier 3	PA
LOFENA	Tier 3	PA
<i>propranolol oral</i>	Tier 2	
<i>timolol maleate oral</i>	Tier 3	PA
<i>tramadol-acetaminophen</i>	Tier 2	AGE (Min 12 Years)
TRI-BUFFERED ASPIRIN	Tier 1	AGE (Min 40 Years and Max 79 Years)
ZIPSOR	Tier 3	PA
ZORVOLEX	Tier 3	PA
<b>ANXIOLYTICS, SEDATIVES, AND HYPNOTICS, MISC</b>		
<i>hydroxyzine hcl oral solution 10 mg/5 ml</i>	Tier 1	AGE (Max 12 Years)
<i>hydroxyzine hcl oral tablet</i>	Tier 2	
<i>hydroxyzine pamoate</i>	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>promethazine oral</i>	Tier 1	AGE (Min 2 Years and Max 64 Years)
<i>promethazine rectal suppository 12.5 mg, 25 mg</i>	Tier 1	QL (4 suppositories per 1 day); AGE (Min 2 Years and Max 64 Years)
<i>promethazine rectal suppository 50 mg</i>	Tier 1	QL (2 suppositories per 1 day); AGE (Min 2 Years and Max 64 Years)
VISTARIL ORAL CAPSULE 25 MG	Tier 3	PA
<b>BARBITURATES (ANXIOLYTIC, SEDATIVE/HYP)</b>		
ASCOMP WITH CODEINE	Tier 3	PA; AGE (Min 12 Years)
<i>butalbital-acetaminop-caf-cod</i>	Tier 3	PA; AGE (Min 12 Years)
<i>butalbital-acetaminophen oral tablet 50-325 mg</i>	Tier 1	QL (4 tablets per 1 day); AGE (Min 10 Years and Max 64 Years)
<i>butalbital-acetaminophen-caff oral tablet</i>	Tier 1	QL (4 tablets per 1 day); AGE (Min 10 Years and Max 64 Years)
<i>butalbital-aspirin-caffeine oral capsule</i>	Tier 1	QL (4 capsules per 1 day); AGE (Max 64 Years)
<i>codeine-bitalbital-asa-caff</i>	Tier 3	PA; AGE (Min 12 Years)
ESGIC ORAL TABLET	Tier 1	QL (4 tablets per 1 day); AGE (Min 10 Years and Max 64 Years)
FIORICET WITH CODEINE	Tier 3	PA; AGE (Min 12 Years)
TENCON	Tier 1	QL (4 tablets per 1 day); AGE (Min 10 Years and Max 64 Years)
<b>BENZODIAZEPINES (ANXIOLYTIC, SEDATIVE/HYP)</b>		
<i>midazolam (pf) injection solution 5 mg/ml</i>	Tier 1	
<i>midazolam injection solution 5 mg/ml</i>	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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



Drug Name	Tier	Restrictions/Limits
<b>CALCITONIN GENE-RELATED PEPTIDE ANTAG.</b>		
AIMOVIG AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 140 MG/ML	Tier 2	PA; QL (1 injector per 30 days); AGE (Min 18 Years)
AIMOVIG AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 70 MG/ML	Tier 2	PA; QL (2 injectors per 30 days); AGE (Min 18 Years)
AJOVY AUTOINJECTOR	Tier 2	PA; QL (1.5 ML per 30 days); AGE (Min 18 Years)
AJOVY SYRINGE	Tier 2	PA; QL (1.5 ML per 30 days); AGE (Min 18 Years)
EMGALITY PEN	Tier 2	PA; QL (1 ML per 30 days); AGE (Min 18 Years)
EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 120 MG/ML	Tier 2	PA; QL (1 ML per 30 days); AGE (Min 18 Years)
EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 300 MG/3 ML (100 MG/ML X 3)	Tier 2	PA; QL (3 syringes per 30 days); AGE (Min 18 Years)
NURTEC ODT	Tier 2	PA; QL (54 tablets per 90 days); AGE (Min 18 Years)
QULIPTA	Tier 3	PA; QL (90 tablets per 90 days); AGE (Min 18 Years)
UBRELVY	Tier 3	PA; QL (16 tablets per 30 dayss); AGE (Min 18 Years)
ZAVZPRET	Tier 3	PA
<b>CATECHOL-O-METHYLTRANSFERASE(COMT)INHIB.</b>		
<i>carbidopa-levodopa-entacapone</i>	Tier 3	PA
<i>entacapone</i>	Tier 3	PA
ONGENTYS	Tier 3	PA
TASMAR ORAL TABLET 100 MG	Tier 3	PA
<i>tolcapone</i>	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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



Drug Name	Tier	Restrictions/Limits
<b>CENTRAL NERVOUS SYSTEM AGENTS, MISC.</b>		
<i>carbidopa</i>	Tier 3	PA
LODOSYN	Tier 3	PA
<i>memantine oral capsule, sprinkle, er 24hr</i>	Tier 3	PA
<i>memantine oral solution</i>	Tier 2	
<i>memantine oral tablet</i>	Tier 2	
<i>memantine oral tablets, dose pack</i>	Tier 2	
NAMENDA TITRATION PAK	Tier 3	PA
NAMENDA XR	Tier 3	PA
NAMZARIC	Tier 3	PA
<b>CYCLOOXYGENASE-2 (COX-2) INHIBITORS</b>		
CELEBREX ORAL CAPSULE 100 MG, 200 MG, 50 MG	Tier 3	QL (2 capsules per 1 day)
CELEBREX ORAL CAPSULE 400 MG	Tier 3	QL (1 capsule per 1 day)
<i>celecoxib</i>	Tier 2	QL (2 capsules per 1 day)
ELYXYB	Tier 3	PA; AGE (Min 18 Years)
SEGLENTIS	Tier 3	PA; QL (4 tablets per 1 day); AGE (Min 12 Years)
<b>DOPAMINE PRECURSORS</b>		
<i>carbidopa-levodopa oral tablet</i>	Tier 2	
<i>carbidopa-levodopa oral tablet extended release</i>	Tier 2	
<i>carbidopa-levodopa oral tablet, disintegrating</i>	Tier 3	PA
<i>carbidopa-levodopa-entacapone</i>	Tier 3	PA
DHIVY	Tier 3	PA
DUOPA	Tier 3	PA
INBRIJA	Tier 3	PA
RYTARY	Tier 3	PA
SINEMET ORAL TABLET 10-100 MG, 25-100 MG	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

Drug Name	Tier	Restrictions/Limits
<b>ERGOT-DERIV. DOPAMINE RECEPTOR AGONISTS</b>		
<i>bromocriptine</i>	Tier 3	PA
<i>cabergoline</i>	Tier 1	
PARLODEL	Tier 3	PA
<b>FIBROMYALGIA AGENTS</b>		
SAVELLA	Tier 2	QL (60 tablets per 30 days)
<b>MONOAMINE OXIDASE B INHIBITORS</b>		
AZILECT	Tier 3	PA; AGE (Min 18 Years)
<i>rasagiline</i>	Tier 3	PA; AGE (Min 18 Years)
<i>selegiline hcl</i>	Tier 3	PA
XADAGO	Tier 3	PA
ZELAPAR	Tier 3	PA
<b>MONOAMINE OXIDASE INHIBITORS</b>		
AZILECT	Tier 3	PA; AGE (Min 18 Years)
<i>rasagiline</i>	Tier 3	PA; AGE (Min 18 Years)
<i>selegiline hcl</i>	Tier 3	PA
ZELAPAR	Tier 3	PA
<b>NONERGOT-DERIV.DOPAMINE RECEPTOR AGONIST</b>		
MIRAPEX ER	Tier 3	PA
NEUPRO	Tier 3	PA; QL (30 patches per 30 days)
<i>pramipexole oral tablet</i>	Tier 2	
<i>pramipexole oral tablet extended release 24 hr</i>	Tier 3	PA
<i>ropinirole oral tablet</i>	Tier 2	
<i>ropinirole oral tablet extended release 24 hr</i>	Tier 3	PA
<b>NONSTEROIDAL ANTI-INFLAMM. AGENTS, MISC</b>		
ARTHROTEC 50	Tier 3	PA
ARTHROTEC 75	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>diclofenac epolamine</i>	Tier 3	PA; QL (2 patches per 1 day)
<i>diclofenac sodium topical drops</i>	Tier 2	
<i>diclofenac sodium topical gel 1 %</i>	Tier 2	
<i>diclofenac sodium topical solution in metered-dose pump</i>	Tier 3	PA
<i>diclofenac-misoprostol</i>	Tier 3	PA
DUAL ACTION PAIN RELIEVER	Tier 3	PA
DUEXIS	Tier 3	PA
FLECTOR	Tier 3	PA; QL (2 patches per 1 day)
<i>hydrocodone-ibuprofen</i>	Tier 3	PA
<i>ibuprofen-famotidine</i>	Tier 3	PA
LICART	Tier 3	PA; QL (15 patches per 30 days)
<i>naproxen-esomeprazole</i>	Tier 3	PA
PENNSAID	Tier 3	PA
<i>sumatriptan-naproxen</i>	Tier 3	PA
TOLECTIN 600	Tier 3	PA
TREXIMET	Tier 3	PA
VIMOVO	Tier 3	PA
<b>OPIOID AGONISTS</b>		
<i>acetaminophen-caff-dihydrocod</i>	Tier 3	PA
<i>acetaminophen-codeine oral solution 120-12 mg/5 ml</i>	Tier 2	AGE (Min 12 Years)
<i>acetaminophen-codeine oral tablet</i>	Tier 2	AGE (Min 12 Years)
ASCOMP WITH CODEINE	Tier 3	PA; AGE (Min 12 Years)
<i>butalbital-acetaminop-caf-cod</i>	Tier 3	PA; AGE (Min 12 Years)
<i>codeine sulfate</i>	Tier 2	QL (180 tablets per 30 days); AGE (Min 12 Years)
<i>codeine-bitalbital-asa-caff</i>	Tier 3	PA; AGE (Min 12 Years)
CONZIP	Tier 3	PA; AGE (Min 12 Years)
DILAUDID ORAL LIQUID	Tier 3	PA; QL (120 ML per 30 days)

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
DILAUDID ORAL TABLET 2 MG	Tier 3	PA; QL (180 tablets per 30 days)
DILAUDID ORAL TABLET 4 MG	Tier 3	PA; QL (165 tablets per 30 days)
DILAUDID ORAL TABLET 8 MG	Tier 3	PA; QL (84 tablets per 30 days)
DISKETS	Tier 3	PA
ENDOCET ORAL TABLET 10-325 MG, 5-325 MG, 7.5-325 MG	Tier 2	
<i>fentanyl citrate buccal lozenge on a handle</i>	Tier 3	PA; QL (120 lozenges per 30 days)
<i>fentanyl citrate buccal tablet, effervescent</i>	Tier 3	PA; QL (120 tablets per 30 days)
<i>fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr</i>	Tier 2	QL (10 patches per 1 fill)
<i>fentanyl transdermal patch 72 hour 37.5 mcg/hour, 62.5 mcg/hour, 87.5 mcg/hour</i>	Tier 3	PA
FENTORA	Tier 3	PA; QL (120 tablets per 30 days)
FIORICET WITH CODEINE	Tier 3	PA; AGE (Min 12 Years)
<i>hydrocodone bitartrate</i>	Tier 3	PA
<i>hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml</i>	Tier 2	
<i>hydrocodone-acetaminophen oral tablet 10-300 mg, 10-325 mg, 5-300 mg, 5-325 mg, 7.5-300 mg, 7.5-325 mg</i>	Tier 2	
<i>hydrocodone-ibuprofen</i>	Tier 3	PA
<i>hydromorphone oral liquid</i>	Tier 2	QL (120 ML per 30 days)
<i>hydromorphone oral tablet 2 mg</i>	Tier 2	QL (180 tablets per 30 days)
<i>hydromorphone oral tablet 4 mg</i>	Tier 2	QL (135 tablets per 30 days)
<i>hydromorphone oral tablet 8 mg</i>	Tier 2	QL (67 tablets per 30 days)
<i>hydromorphone oral tablet extended release 24 hr</i>	Tier 3	PA
<i>hydromorphone rectal</i>	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

Drug Name	Tier	Restrictions/Limits
HYSINGLA ER	Tier 3	PA
<i>levorphanol tartrate</i>	Tier 3	PA
<i>meperidine oral solution</i>	Tier 3	PA; QL (240 ML per 30 days)
<i>meperidine oral tablet 50 mg</i>	Tier 3	PA; QL (120 tablets per 30 days)
METHADONE INTENSOL	Tier 3	PA
<i>methadone oral concentrate</i>	Tier 3	PA
<i>methadone oral solution</i>	Tier 3	PA
<i>methadone oral tablet</i>	Tier 3	PA
<i>methadone oral tablet, soluble</i>	Tier 3	PA
METHADOSE ORAL CONCENTRATE	Tier 3	PA
METHADOSE ORAL TABLET, SOLUBLE	Tier 3	PA
<i>morphine concentrate oral solution</i>	Tier 2	QL (120 ML per 30 days)
<i>morphine concentrate oral syringe 10 mg/0.5 ml</i>	Tier 2	
<i>morphine oral capsule, er multiphase 24 hr</i>	Tier 3	PA
<i>morphine oral capsule, extend. release pellets 10 mg, 100 mg, 20 mg, 30 mg, 50 mg, 60 mg, 80 mg</i>	Tier 3	PA
<i>morphine oral solution</i>	Tier 2	QL (240 ML per 30 days)
<i>morphine oral tablet 15 mg</i>	Tier 2	QL (180 tablets per 30 days)
<i>morphine oral tablet 30 mg</i>	Tier 2	QL (90 tablets per 30 days)
<i>morphine oral tablet extended release</i>	Tier 2	
<i>morphine rectal</i>	Tier 2	
MS CONTIN	Tier 3	PA
NUCYNTA	Tier 3	PA
NUCYNTA ER	Tier 3	PA
<i>oxycodone oral capsule</i>	Tier 3	PA; QL (90 capsules per 30 days)
<i>oxycodone oral concentrate</i>	Tier 3	PA; QL (90 ML per 30 days)
<i>oxycodone oral solution</i>	Tier 2	QL (240 ML per 30 days)
<i>oxycodone oral tablet 10 mg, 15 mg, 5 mg</i>	Tier 2	QL (90 tablets per 30 days)

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

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

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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



<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
ROXYBOND ORAL TABLET, ORAL ONLY 15 MG, 5 MG	Tier 3	QL (3 tablets per 1 day)
ROXYBOND ORAL TABLET, ORAL ONLY 30 MG	Tier 3	QL (2 tablets per 1 day)
SEGLENTIS	Tier 3	PA; QL (4 tablets per 1 day); AGE (Min 12 Years)
<i>tramadol oral capsule, er biphasic 24 hr 17-83</i>	Tier 3	PA; AGE (Min 12 Years)
<i>tramadol oral capsule, er biphasic 24 hr 25-75 100 mg, 200 mg</i>	Tier 3	PA; AGE (Min 12 Years)
<i>tramadol oral solution</i>	Tier 3	PA; QL (80 ML per 1 day); AGE (Min 12 Years)
<i>tramadol oral tablet 100 mg, 50 mg</i>	Tier 2	AGE (Min 12 Years)
<i>tramadol oral tablet extended release 24 hr</i>	Tier 2	PA; AGE (Min 12 Years)
<i>tramadol oral tablet, er multiphasic 24 hr</i>	Tier 2	PA; AGE (Min 12 Years)
<i>tramadol-acetaminophen</i>	Tier 2	AGE (Min 12 Years)
XTAMPZA ER	Tier 3	PA; QL (60 capsules per 30 days)
<b>OPIOID ANTAGONIST</b>		
KLOXXADO	Tier 1	QL (2 devices per 90 days)
<i>naloxone injection solution</i>	Tier 1	QL (2 doses per 30 days)
<i>naloxone injection syringe</i>	Tier 1	QL (2 doses per 30 days)
<i>naloxone nasal</i>	Tier 2	QL (6 doses per 90 days)
NARCAN	Tier 2	QL (6 doses per 90 days)
OPVEE	Tier 1	QL (6 devices per 90 days)
ZIMHI	Tier 1	QL (3 syringes per 90 days)
<b>OPIOID PARTIAL AGONISTS</b>		
BELBUCA	Tier 3	PA; QL (60 films per 30 days)
<i>buprenorphine</i>	Tier 3	PA; QL (6 patches per 28 days)
<i>butorphanol nasal</i>	Tier 3	PA; QL (15 ML per 30 days)
BUTRANS	Tier 2	QL (6 patches per 28 days)
<i>pentazocine-naloxone</i>	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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



Drug Name	Tier	Restrictions/Limits
<b>PHENOTHIAZINES</b>		
<i>prochlorperazine</i>	Tier 1	QL (2 suppositories per 1 day)
<i>prochlorperazine maleate</i>	Tier 1	QL (4 tablets per 1 day)
<b>RESPIRATORY AND CNS STIMULANTS</b>		
<i>acetaminophen-caff-dihydrocod</i>	Tier 3	PA
ASCOMP WITH CODEINE	Tier 3	PA; AGE (Min 12 Years)
<i>butalbital-acetaminop-caf-cod</i>	Tier 3	PA; AGE (Min 12 Years)
<i>butalbital-acetaminophen-caff oral tablet</i>	Tier 1	QL (4 tablets per 1 day); AGE (Min 10 Years and Max 64 Years)
<i>butalbital-aspirin-caffeine oral capsule</i>	Tier 1	QL (4 capsules per 1 day); AGE (Max 64 Years)
<i>caffeine citrate oral</i>	Tier 1	AGE (Max 1 Years)
<i>codeine-bitalbital-asa-caff</i>	Tier 3	PA; AGE (Min 12 Years)
ESGIC ORAL TABLET	Tier 1	QL (4 tablets per 1 day); AGE (Min 10 Years and Max 64 Years)
FIORICET WITH CODEINE	Tier 3	PA; AGE (Min 12 Years)
<b>REVERSIBLE COX-1/COX-2 INHIBITORS</b>		
ALL DAY PAIN RELIEF	Tier 2	
ALL DAY RELIEF	Tier 2	
CHILDREN'S IBUPROFEN	Tier 2	
DAYPRO	Tier 3	PA
<i>diclofenac potassium oral capsule</i>	Tier 3	PA
<i>diclofenac potassium oral tablet</i>	Tier 3	PA
<i>diclofenac sodium oral tablet extended release 24 hr</i>	Tier 3	PA
<i>diclofenac sodium oral tablet, delayed release (dr/ec)</i>	Tier 2	
<i>diflunisal</i>	Tier 3	PA
EC-NAPROXEN	Tier 3	PA
<i>etodolac</i>	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
FELDENE	Tier 3	PA
<i>fenoprofen oral capsule 400 mg</i>	Tier 3	PA
<i>fenoprofen oral tablet</i>	Tier 3	PA
<i>flurbiprofen oral tablet 100 mg</i>	Tier 3	PA
IBU	Tier 2	
IBU-200	Tier 2	
IBUPROFEN IB ORAL TABLET,CHEWABLE	Tier 2	
IBUPROFEN JR STRENGTH	Tier 2	
<i>ibuprofen oral capsule</i>	Tier 2	
<i>ibuprofen oral drops,suspension</i>	Tier 2	
<i>ibuprofen oral suspension</i>	Tier 2	
<i>ibuprofen oral tablet</i>	Tier 2	
INDOCIN ORAL	Tier 3	PA
<i>indomethacin oral capsule</i>	Tier 2	
<i>indomethacin oral capsule, extended release</i>	Tier 3	PA
<i>indomethacin oral suspension</i>	Tier 3	PA
INFANT'S IBUPROFEN	Tier 2	
<i>ketoprofen oral capsule 50 mg, 75 mg</i>	Tier 2	
<i>ketoprofen oral capsule,ext rel. pellets 24 hr 200 mg</i>	Tier 3	PA
<i>ketorolac nasal</i>	Tier 3	PA; QL (5 doses per 1 fill)
<i>ketorolac oral</i>	Tier 2	QL (21 tablets per 1 fill)
LOFENA	Tier 3	PA
<i>meclofenamate</i>	Tier 3	PA
<i>mefenamic acid</i>	Tier 3	PA
<i>meloxicam oral tablet</i>	Tier 2	
<i>meloxicam submicronized</i>	Tier 3	PA
<i>nabumetone</i>	Tier 2	
NALFON ORAL CAPSULE 400 MG	Tier 3	PA
NALFON ORAL TABLET	Tier 3	PA
NAPRELAN CR	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>naproxen oral suspension</i>	Tier 3	PA
<i>naproxen oral tablet</i>	Tier 2	
<i>naproxen oral tablet, delayed release (dr/ec)</i>	Tier 3	PA
<i>naproxen sodium oral capsule</i>	Tier 2	
<i>naproxen sodium oral tablet 220 mg</i>	Tier 2	
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	Tier 3	PA
<i>naproxen sodium oral tablet, er multiphase 24 hr 375 mg, 500 mg</i>	Tier 3	PA
<i>oxaprozin oral tablet</i>	Tier 3	PA
<i>piroxicam</i>	Tier 3	PA
RELAFEN DS	Tier 3	PA
SPRIX	Tier 3	PA; QL (5 doses per 1 fill)
<i>sulindac</i>	Tier 2	
ZIPSOR	Tier 3	PA
ZORVOLEX	Tier 3	PA
<b>SALICYLATES</b>		
ASCOMP WITH CODEINE	Tier 3	PA; AGE (Min 12 Years)
ASPIRIN CHILDRENS	Tier 1	QL (1 tablet per 1 day)
<i>aspirin oral tablet</i>	Tier 1	QL (1 tablet per 1 day); AGE (Min 40 Years and Max 79 Years)
<i>aspirin oral tablet, chewable</i>	Tier 1	QL (1 tablet per 1 day)
<i>aspirin oral tablet, delayed release (dr/ec) 325 mg</i>	Tier 1	QL (1 tablet per 1 day); AGE (Min 40 Years and Max 79 Years)
<i>aspirin oral tablet, delayed release (dr/ec) 81 mg</i>	Tier 1	QL (1 tablet per 1 day)
<i>aspirin rectal suppository 300 mg</i>	Tier 1	
<i>aspirin, buffd-calcium carb-mag</i>	Tier 1	AGE (Min 40 Years and Max 79 Years)
<i>aspirin-dipyridamole</i>	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

Drug Name	Tier	Restrictions/Limits
BAYER ASPIRIN	Tier 1	QL (1 tablet per 1 day); AGE (Min 40 Years and Max 79 Years)
BAYER CHEWABLE ASPIRIN	Tier 1	QL (1 tablet per 1 day)
BAYER LOW DOSE ASPIRIN	Tier 1	QL (1 tablet per 1 day)
BUFFERIN	Tier 1	AGE (Min 40 Years and Max 79 Years)
<i>butalbital-aspirin-caffeine oral capsule</i>	Tier 1	QL (4 capsules per 1 day); AGE (Max 64 Years)
CHILDREN'S ASPIRIN	Tier 1	QL (1 tablet per 1 day)
<i>codeine-butalbital-asa-caff</i>	Tier 3	PA; AGE (Min 12 Years)
ECOTRIN LOW STRENGTH	Tier 1	QL (1 tablet per 1 day)
NORGESIC	Tier 3	PA
NORGESIC FORTE	Tier 3	PA
<i>orphenadrine-asa-caffeine oral tablet 25-385-30 mg</i>	Tier 3	PA
TRI-BUFFERED ASPIRIN	Tier 1	AGE (Min 40 Years and Max 79 Years)
YOSPRALA	Tier 3	PA
<b>SEL.SEROTONIN,NOREPI REUPTAKE INHIBITOR</b>		
SAVELLA	Tier 2	QL (60 tablets per 30 days)
<b>SELECTIVE SEROTONIN AGONISTS</b>		
<i>almotriptan malate</i>	Tier 3	PA; QL (9 tablets per 1 fill)
<i>eletriptan</i>	Tier 3	PA; QL (12 tablets per 1 fill)
FROVA	Tier 3	PA; QL (18 tablets per 1 fill)
<i>frovatriptan</i>	Tier 3	PA; QL (18 tablets per 1 fill)
IMITREX ORAL	Tier 3	PA; QL (18 tablets per 1 fill)
IMITREX STATDOSE PEN	Tier 3	PA; QL (4 injectors per 1 fill)
IMITREX STATDOSE REFILL	Tier 3	PA; QL (4 cartridges per 1 fill)
IMITREX SUBCUTANEOUS	Tier 3	PA; QL (2 ML per 1 fill)
MAXALT ORAL TABLET 10 MG	Tier 3	PA; QL (18 tablets per 1 fill)

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
MAXALT-MLT ORAL TABLET,DISINTEGRATING 10 MG	Tier 3	PA; QL (18 tablets per 1 fill)
<i>naratriptan</i>	Tier 3	PA; QL (9 tablets per 1 fill)
ONZETRA XSAIL	Tier 3	PA
RELPAX	Tier 3	PA; QL (12 tablets per 1 fill)
REYVOW	Tier 3	PA; QL (8 tablets per 30 days); AGE (Min 18 Years)
<i>rizatriptan</i>	Tier 2	QL (18 tablets per 1 fill)
<i>sumatriptan</i>	Tier 3	PA; QL (6 doses per 1 fill)
<i>sumatriptan succinate oral</i>	Tier 2	QL (18 tablets per 1 fill)
<i>sumatriptan succinate subcutaneous cartridge</i>	Tier 2	QL (4 cartridges per 1 fill)
<i>sumatriptan succinate subcutaneous pen injector</i>	Tier 2	QL (4 injectors per 1 fill)
<i>sumatriptan succinate subcutaneous solution</i>	Tier 2	QL (2 ML per 1 fill)
<i>sumatriptan-naproxen</i>	Tier 3	PA
TOSYMRA	Tier 3	PA; QL (6 units per 1 fill)
TREXIMET	Tier 3	PA
ZEMBRACE SYMTOUCH	Tier 3	PA
<i>zolmitriptan nasal spray,non-aerosol 5 mg</i>	Tier 3	PA
<i>zolmitriptan oral</i>	Tier 3	PA; QL (12 tablets per 1 fill)
ZOMIG NASAL	Tier 3	PA
ZOMIG ORAL	Tier 3	PA; QL (12 tablets per 1 fill)
<b>VESICULAR MONOAMINE TRANSPORT2 INHIBITOR</b>		
AUSTEDO	Tier 1	PA; AGE (Min 18 Years)
AUSTEDO XR	Tier 1	PA; AGE (Min 18 Years)
INGREZZA	Tier 1	PA; AGE (Min 18 Years)
INGREZZA INITIATION PK(TARDIV)	Tier 1	PA; AGE (Min 18 Years)
<b>WAKEFULNESS-PROMOTING AGENTS</b>		
<i>sodium oxybate</i>	Tier 1	PA; QL (540 ML per 30 days); AGE (Min 7 Years)

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

Drug Name	Tier	Restrictions/Limits
XYWAV	Tier 1	PA; QL (540 ML per 30 days); AGE (Min 7 Years)
<b>DENTAL AGENTS</b>		
<b>DENTAL AGENTS</b>		
DENTA 5000 PLUS	Tier 1	
<i>fluoride (sodium) oral drops</i>	Tier 1	QL (4 ML per 1 day); AGE (Max 16 Years)
<i>fluoride (sodium) oral tablet, chewable</i>	Tier 1	QL (1 tablet per 1 day); AGE (Max 16 Years)
LUDENT FLUORIDE	Tier 1	QL (1 tablet per 1 day); AGE (Max 16 Years)
SF	Tier 1	
SF 5000 PLUS	Tier 1	
SODIUM FLUORIDE 5000 PLUS	Tier 1	
<b>DEVICES</b>		
<b>DEVICES</b>		
ACE AEROSOL CLOUD ENHANCER	Tier 1	QL (4 units per 1 year)
AEROCHAMBER MINI	Tier 1	QL (4 units per 1 year)
AEROCHAMBER MV	Tier 1	QL (4 units per 1 year)
AEROCHAMBER PLUS FLOW-VU	Tier 1	QL (4 units per 1 year)
AEROCHAMBER PLUS FLOW-VU,L MSK	Tier 1	QL (4 units per 1 year)
AEROCHAMBER PLUS FLOW-VU,M MSK	Tier 1	QL (4 units per 1 year)
AEROCHAMBER PLUS FLOW-VU,S MSK	Tier 1	QL (4 units per 1 year)
AEROCHAMBER PLUS Z STAT	Tier 1	QL (4 units per 1 year)
AEROCHAMBER PLUS Z STAT LG MSK	Tier 1	QL (4 units per 1 year)
AEROCHAMBER PLUS Z STAT MD MSK	Tier 1	QL (4 units per 1 year)
AEROCHAMBER PLUS Z STAT SM MSK	Tier 1	QL (4 units per 1 year)
AEROCHAMBER Z-STAT PLUS-FLW SG	Tier 1	QL (4 units per 1 year)
AEROTRACH PLUS	Tier 1	QL (4 units per 1 year)
AIRZONE PEAK FLOW METER	Tier 1	QL (4 units per 1 year)
ASTHMA CHECK METER	Tier 1	QL (4 units per 1 year)
BD AUTOSHIELD DUO PEN NEEDLE	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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



Drug Name	Tier	Restrictions/Limits
BD INSULIN SYRINGE (HALF UNIT)	Tier 1	
BD INSULIN SYRINGE U-500	Tier 1	
BD INSULIN SYRINGE ULTRA-FINE	Tier 1	
BD NANO 2ND GEN PEN NEEDLE	Tier 1	
BD ULTRA-FINE MICRO PEN NEEDLE	Tier 1	
BD ULTRA-FINE MINI PEN NEEDLE	Tier 1	
BD ULTRA-FINE NANO PEN NEEDLE	Tier 1	
BD ULTRA-FINE ORIG PEN NEEDLE	Tier 1	
BD ULTRA-FINE SHORT PEN NEEDLE	Tier 1	
BD VEO INSULIN SYR (HALF UNIT)	Tier 1	
BD VEO INSULIN SYRINGE UF	Tier 1	
BREATHERITE MDI SPACER	Tier 1	QL (4 units per 1 year)
BREATHERITE VALVED MDI CHAMBER	Tier 1	QL (4 units per 1 year)
BREATHERITE VALVED MDI SPACER	Tier 1	QL (4 units per 1 year)
EASIVENT HOLDING CHAMBER	Tier 1	QL (4 units per 1 year)
EASIVENT MASK LARGE	Tier 1	QL (4 units per 1 year)
EASIVENT MASK MEDIUM	Tier 1	QL (4 units per 1 year)
EASIVENT MASK SMALL	Tier 1	QL (4 units per 1 year)
FASTEP COVID-19 AG HOME TEST	Tier 1	
FEMCAP	Tier 1	
FREESTYLE CONTROL	Tier 1	QL (1 bottle per 90 days)
FREESTYLE FREEDOM	Tier 1	
FREESTYLE FREEDOM LITE	Tier 1	QL (1 meter per 1 year)
FREESTYLE INSULINX	Tier 1	QL (1 meter per 2 years)
FREESTYLE LANCETS	Tier 1	
FREESTYLE LITE METER	Tier 1	QL (1 meter per 1 year)
FREESTYLE PRECISION NEO METER	Tier 1	QL (1 meter per 1 year)
GLUCOSE KETONE CONTROL SOLN	Tier 1	QL (1 bottle per 90 days)
IN-CHECK NASAL WITH MASK	Tier 1	QL (4 units per 1 year)
IN-CHECK ORAL FLOW METER	Tier 1	QL (4 units per 1 year)
<i>lancets</i>	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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



<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
LITE TOUCH-MEDIUM MASK	Tier 1	QL (4 units per 1 year)
LITEAIRE MDI CHAMBER	Tier 1	QL (4 units per 1 year)
LITETOUGH-LARGE MASK	Tier 1	QL (4 units per 1 year)
LITETOUGH-SMALL MASK	Tier 1	QL (4 units per 1 year)
MICROCHAMBER	Tier 1	QL (4 units per 1 year)
MICROLIFE PEAK FLOW METER	Tier 1	QL (4 units per 1 year)
MICROSPACER	Tier 1	QL (4 units per 1 year)
MINI WRIGHT PEAK FLOW METER	Tier 1	QL (4 units per 1 year)
MOUTHPIECE	Tier 1	QL (4 units per 1 year)
ONE WAY VALVED MOUTHPIECE	Tier 1	QL (4 units per 1 year)
OPTICHAMBER ADULT MASK-LARGE	Tier 1	QL (4 units per 1 year)
OPTICHAMBER DIAMOND LG MASK	Tier 1	QL (4 units per 1 year)
OPTICHAMBER DIAMOND VHC	Tier 1	QL (4 units per 1 year)
OPTICHAMBER DIAMOND-MED MSK	Tier 1	QL (4 units per 1 year)
OPTICHAMBER DIAMOND-SML MASK	Tier 1	QL (4 units per 1 year)
PANDA MASK	Tier 1	QL (4 units per 1 year)
PEAK AIR PEAK FLOW METER	Tier 1	QL (4 units per 1 year)
PEDIATRIC MEDIUM MASK	Tier 1	QL (4 units per 1 year)
PEDIATRIC PANDA MASK	Tier 1	QL (4 units per 1 year)
PEDIATRIC SMALL MASK	Tier 1	QL (4 units per 1 year)
PERSONAL BEST FULL RANGE	Tier 1	QL (4 units per 1 year)
PIKO 1	Tier 1	QL (4 units per 1 year)
POCKET CHAMBER	Tier 1	QL (4 units per 1 year)
POCKET PEAK FLOW METER	Tier 1	QL (4 units per 1 year)
PRECISION XTRA B-KETONE	Tier 1	
PRECISION XTRA MONITOR	Tier 1	QL (1 meter per 1 year)
PRIMEAIRE	Tier 1	QL (4 units per 1 year)
PRO COMFORT SPACER-ADULT MASK	Tier 1	QL (4 units per 1 year)
PRO COMFORT SPACER-CHILD MASK	Tier 1	QL (4 units per 1 year)
PROCARE SPACER WITH ADULT MASK	Tier 1	QL (4 units per 1 year)
PROCARE SPACER WITH CHILD MASK	Tier 1	QL (4 units per 1 year)

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
PROCHAMBER	Tier 1	QL (4 units per 1 year)
RITEFLO AEROCHAMBER	Tier 1	QL (4 units per 1 year)
SIDESTREAM PEDIATRIC FACE MASK	Tier 1	QL (4 units per 1 year)
SILICONE MASK - INFANT	Tier 1	QL (4 units per 1 year)
SILICONE MASK - PEDIATRIC	Tier 1	QL (4 units per 1 year)
<i>sodium chloride inhalation solution for nebulization 0.9 %</i>	Tier 1	
SPEEDYSWAB COVID-19 HOME TEST	Tier 1	
TRUZONE PEAK FLOW METER	Tier 1	QL (4 units per 1 year)
VORTEX ADULT MASK	Tier 1	QL (4 units per 1 year)
VORTEX HOLDING CHAMBER	Tier 1	QL (4 units per 1 year)
VORTEX VHC FROG MASK-CHILD	Tier 1	QL (4 units per 1 year)
VORTEX VHC LADYBUG MASK-TODDLR	Tier 1	QL (4 units per 1 year)
<b>DIAGNOSTIC AGENTS</b>		
<b>CARDIAC FUNCTION</b>		
<i>aspirin-dipyridamole</i>	Tier 3	PA
<i>dipyridamole oral</i>	Tier 3	PA
<b>DIABETES MELLITUS</b>		
FREESTYLE INSULINX TEST STRIPS	Tier 1	
FREESTYLE LITE STRIPS	Tier 1	
FREESTYLE PRECISION NEO STRIPS	Tier 1	
FREESTYLE TEST	Tier 1	
PRECISION XTRA TEST	Tier 1	
<b>ELECTROLYTIC, CALORIC, AND WATER BALANCE</b>		
<b>ACIDIFYING AGENTS</b>		
K-PHOS NO 2	Tier 1	
K-PHOS ORIGINAL	Tier 1	
<b>ALKALINIZING AGENTS</b>		
<i>potassium citrate oral tablet extended release</i>	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>potassium citrate-citric acid</i>	Tier 1	
<i>sodium citrate-citric acid oral solution 500-334 mg/5 ml</i>	Tier 1	
<b>AMMONIA DETOXICANTS</b>		
<i>lactulose oral solution 10 gram/15 ml (15 ml)</i>	Tier 1	QL (180 ML per 1 day)
<b>CARBONIC ANHYDRASE INHIBITORS</b>		
<i>acetazolamide oral capsule, extended release</i>	Tier 1	QL (2 capsules per 1 day)
<i>acetazolamide oral tablet</i>	Tier 1	QL (4 tablets per 1 day)
<b>DIURETICS, MISCELLANEOUS</b>		
<i>theophylline oral elixir</i>	Tier 1	
<i>theophylline oral solution</i>	Tier 1	
<i>theophylline oral tablet extended release 12 hr 300 mg, 450 mg</i>	Tier 1	
<i>theophylline oral tablet extended release 24 hr</i>	Tier 1	
<b>IRRIGATING SOLUTIONS</b>		
<i>sodium chloride inhalation solution for nebulization 0.9 %</i>	Tier 1	
<b>LOOP DIURETICS (40:28)</b>		
<i>furosemide oral solution 10 mg/ml, 40 mg/5 ml (8 mg/ml)</i>	Tier 1	AGE (Max 12 Years)
<i>furosemide oral tablet</i>	Tier 1	QL (2 tablets per 1 day)
<i>toremide oral tablet 10 mg, 20 mg</i>	Tier 1	QL (4 tablets per 1 day)
<i>toremide oral tablet 100 mg, 5 mg</i>	Tier 1	QL (2 tablets per 1 day)
<b>PHOSPHATE-REMOVING AGENTS</b>		
AURYXIA	Tier 3	PA
<i>calcium acetate(phosphat bind)</i>	Tier 2	PA
FOSRENOL	Tier 3	PA
<i>lanthanum</i>	Tier 3	PA
RENVELA	Tier 3	PA
<i>sevelamer carbonate oral powder in packet</i>	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>sevelamer carbonate oral tablet</i>	Tier 2	PA
<i>sevelamer hcl</i>	Tier 3	PA
VELPHORO	Tier 3	PA
<b>POTASSIUM-REMOVING AGENTS</b>		
<i>sodium polystyrene sulfonate oral powder</i>	Tier 1	
<b>POTASSIUM-SPARING DIURETICS</b>		
<i>amiloride</i>	Tier 1	QL (1 tablet per 1 day)
<i>amiloride-hydrochlorothiazide</i>	Tier 1	QL (2 tablets per 1 day)
<i>spironolactone oral tablet</i>	Tier 1	QL (2 tablets per 1 day)
<i>spironolacton-hydrochlorothiaz</i>	Tier 1	QL (3 tablets per 1 day)
<i>triamterene-hydrochlorothiazid</i>	Tier 1	
<b>REPLACEMENT PREPARATIONS</b>		
ACTICAL	Tier 1	
ANTACID (CALCIUM CARBONATE) ORAL TABLET,CHEWABLE 200 MG CALCIUM (500 MG)	Tier 1	
ANTACID CALCIUM	Tier 1	
ANTACID EXT STR (CALCIUM CARB)	Tier 1	
ANTACID EXTRA-STRENGTH ORAL TABLET,CHEWABLE 300 MG (750 MG)	Tier 1	
ANTACID ULTRA STRENGTH ORAL TABLET,CHEWABLE 400 MG CALCIUM (1,000 MG)	Tier 1	
BEELITH	Tier 1	
BIO-35, GLUTEN FREE	Tier 1	
BIOCAL	Tier 1	
CALCIUM 500 + D ORAL TABLET	Tier 1	
CALCIUM 500 WITH D	Tier 1	
CALCIUM 600	Tier 1	
CALCIUM 600 + D(3) ORAL TABLET	Tier 1	
CALCIUM ANTACID	Tier 1	
<i>calcium carbonate oral suspension</i>	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>calcium carbonate oral tablet 500 mg calcium (1,250 mg), 600 mg calcium (1,500 mg)</i>	Tier 1	
<i>calcium carbonate oral tablet, chewable 200 mg calcium (500 mg), 260 mg calcium (650 mg), 400 mg calcium (1,000 mg)</i>	Tier 1	
<i>calcium carbonate-vitamin d3 oral tablet 250 mg-3.125 mcg (125 unit), 500 mg-10 mcg (400 unit), 500 mg-15 mcg (600 unit), 500 mg-3.125 mcg (125 unit), 500 mg-5 mcg (200 unit), 600 mg-10 mcg (400 unit), 600 mg-20 mcg (800 unit), 600 mg-5 mcg (200 unit)</i>	Tier 1	
<i>calcium carbonate-vitamin d3 oral tablet, chewable 500 mg-2.5 mcg (100 unit)</i>	Tier 1	
CALCIUM CITRATE + D	Tier 1	
<i>calcium citrate oral tablet</i>	Tier 1	
<i>calcium citrate-vitamin d3 oral tablet 315 mg-5 mcg (200 unit), 315 mg-6.25 mcg (250 unit)</i>	Tier 1	
CALCIUM WITH VITAMIN D	Tier 1	
CAL-GEST ANTACID	Tier 1	
CALTRATE WITH VITAMIN D3	Tier 1	
CERALYTE-70 ORAL SOLUTION	Tier 1	
CITRACAL + D MAXIMUM	Tier 1	
CITRACAL-D3 MAXIMUM PLUS	Tier 1	
DAILY MULTIPLE FOR WOMEN	Tier 1	
<i>electrolytes-dextrose oral solution</i>	Tier 1	
ENFAMIL ENFALYTE	Tier 1	
FLAVOR CHEWS ANTACID	Tier 1	
GLYCOPHOS	Tier 1	
HAIR,SKIN AND NAILS ORAL TABLET 1 MG IRON-66.7 MCG-1,000 MCG	Tier 1	
KLOR-CON/EF	Tier 1	
MAG GLYCINATE	Tier 1	
MAG-G	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

Drug Name	Tier	Restrictions/Limits
MAGINEX	Tier 1	
MAGNESIUM (OXIDE/AA CHELATE)	Tier 1	
<i>magnesium amino acid chelate</i>	Tier 1	
<i>magnesium chloride oral tablet, delayed release (dr/ec) 70 mg</i>	Tier 1	
<i>magnesium citrate oral tablet</i>	Tier 1	
<i>magnesium gluconate oral tablet 27 mg magnesium (500 mg), 27.5 mg magnesium (500 mg), 30 mg (550 mg)</i>	Tier 1	
<i>magnesium oral tablet 200 mg</i>	Tier 1	
MAGTAB	Tier 1	
MEGA MULTI FOR WOMEN	Tier 1	
MULTI FOR HER ORAL TABLET	Tier 1	
NESTABS	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
NESTABS DHA	Tier 1	QL (2 capsules per 1 day); AGE (Min 12 Years and Max 55 Years)
NEWGEN	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
NU-MAG	Tier 1	
ONE DAILY WOMEN'S ORAL TABLET 18 MG IRON-400 MCG-450 MG CA	Tier 1	
ONE-A-DAY ENERGY	Tier 1	
ONE-A-DAY MENOPAUSE FORMULA	Tier 1	
ONE-A-DAY TEEN ADVANTAGE ORAL TABLET 9 MG IRON-400 MCG	Tier 1	
ONE-A-DAY WOMEN'S ACTIVE	Tier 1	
ONE-A-DAY WOMEN'S HEALTHY SKIN	Tier 1	
ONE-A-DAY WOMEN'S PETITES	Tier 1	
OPTISOURCE	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

Drug Name	Tier	Restrictions/Limits
ORALYTE	Tier 1	
ORAZINC	Tier 1	
OS-CAL 500 + D3	Tier 1	
OYSCO 500/D	Tier 1	
OYSTER SHELL + D3	Tier 1	
OYSTER SHELL CALCIUM	Tier 1	
OYSTER SHELL CALCIUM 500	Tier 1	
OYSTER SHELL CALCIUM-VIT D3	Tier 1	
OYSTERCAL-D	Tier 1	
PEDIALYTE ADVANCED CARE	Tier 1	
PEDIALYTE FREEZER POPS	Tier 1	
PEDIALYTE ORAL SOLUTION	Tier 1	
PEDIALYTE SINGLES	Tier 1	
PEDIATRIC ELECTROLYTE ORAL SOLUTION	Tier 1	
PEDIATRIC FREEZER POPS	Tier 1	
PEDIAVANCE	Tier 1	
<i>potassium chloride oral capsule, extended release</i>	Tier 1	
<i>potassium chloride oral tablet extended release</i>	Tier 1	
<i>potassium chloride oral tablet, er particles/crystals 10 meq, 20 meq</i>	Tier 1	
<i>potassium phosphate m-/d-basic intravenous solution 3 mmol/ml</i>	Tier 1	
PRENATABS RX	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL COMPLETE	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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



Drug Name	Tier	Restrictions/Limits
PRENATAL PLUS (CALCIUM CARB)	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL TABLET	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL VITAMIN PLUS LOW IRON	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL VITAMIN WITH MINERALS	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRO-CAL	Tier 1	
QUINTABS-M	Tier 1	
SLOW-MAG	Tier 1	
SLOWMAG MUSCLE RECOVERY	Tier 1	
THERAPEUTIC-M ORAL TABLET 9 MG IRON-400 MCG	Tier 1	
TRINATAL RX 1	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
TUMS	Tier 1	
TUMS E-X	Tier 1	
TUMS EXTRA STRENGTH SMOOTHIES	Tier 1	
TUMS FRESHERS	Tier 1	
TUMS ULTRA ORAL TABLET,CHEWABLE 400 MG CALCIUM (1,000 MG)	Tier 1	
ULTRA FREEDA	Tier 1	
ULTRA STRENGTH ANTACID	Tier 1	
WESTAB PLUS	Tier 1	
WOMEN'S ONE DAILY ORAL TABLET 18 MG IRON-400 MCG-500 MG CA	Tier 1	
<i>zinc gluconate oral tablet 100 mg</i>	Tier 1	
<i>zinc sulfate oral</i>	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

Drug Name	Tier	Restrictions/Limits
ZINC-220	Tier 1	
<b>THIAZIDE DIURETICS</b>		
ACCURETIC ORAL TABLET 20-25 MG	Tier 3	PA
<i>amiloride-hydrochlorothiazide</i>	Tier 1	QL (2 tablets per 1 day)
<i>amlodipine-valsartan-hcthiazid</i>	Tier 2	
ATACAND HCT	Tier 3	PA
AVALIDE	Tier 3	PA
<i>benazepril-hydrochlorothiazide</i>	Tier 2	
BENICAR HCT	Tier 3	PA
<i>bisoprolol-hydrochlorothiazide</i>	Tier 2	
<i>candesartan-hydrochlorothiazid</i>	Tier 3	PA
<i>captopril-hydrochlorothiazide</i>	Tier 3	PA
DIOVAN HCT	Tier 3	PA
DIURIL	Tier 1	AGE (Max 12 Years)
<i>enalapril-hydrochlorothiazide</i>	Tier 2	
EXFORGE HCT	Tier 3	PA
<i>fosinopril-hydrochlorothiazide</i>	Tier 3	PA
<i>hydrochlorothiazide</i>	Tier 1	
HYZAAR	Tier 3	PA
<i>irbesartan-hydrochlorothiazide</i>	Tier 3	PA
<i>lisinopril-hydrochlorothiazide</i>	Tier 2	
<i>losartan-hydrochlorothiazide</i>	Tier 2	
LOTENSIN HCT	Tier 3	PA
<i>methyldopa-hydrochlorothiazide</i>	Tier 3	PA
<i>metoprolol ta-hydrochlorothiaz</i>	Tier 3	PA
MICARDIS HCT	Tier 3	PA
<i>olmesartan-amlodipin-hcthiazid</i>	Tier 3	PA
<i>olmesartan-hydrochlorothiazide</i>	Tier 2	
<i>propranolol-hydrochlorothiazid</i>	Tier 3	PA
<i>quinapril-hydrochlorothiazide</i>	Tier 3	PA
<i>spironolacton-hydrochlorothiaz</i>	Tier 1	QL (3 tablets per 1 day)

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>telmisartan-hydrochlorothiazid</i>	Tier 3	PA
<i>triamterene-hydrochlorothiazid</i>	Tier 1	
TRIBENZOR	Tier 3	PA
<i>valsartan-hydrochlorothiazide</i>	Tier 2	
VASERETIC	Tier 3	PA
ZESTORETIC	Tier 3	PA
<b>THIAZIDE-LIKE DIURETICS</b>		
<i>atenolol-chlorthalidone</i>	Tier 2	
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	Tier 1	QL (4 tablets per 1 day)
EDARBYCLOR	Tier 3	PA
<i>indapamide</i>	Tier 1	QL (1 tablet per 1 day)
<i>metolazone</i>	Tier 1	QL (1 tablet per 1 day)
TENORETIC 100	Tier 3	PA
TENORETIC 50	Tier 3	PA
<b>URICOSURIC AGENTS</b>		
<i>probenecid</i>	Tier 2	
<i>probenecid-colchicine</i>	Tier 2	
<b>ENZYMES</b>		
<b>ENZYMES</b>		
PULMOZYME	Tier 1	PA; QL (75 EA per 30 days)
<b>EYE, EAR, NOSE AND THROAT (EENT) PREPS.</b>		
<b>ALPHA-ADRENERGIC AGONISTS (EENT)</b>		
ALPHAGAN P	Tier 3	PA
<i>apraclonidine</i>	Tier 2	
<i>brimonidine ophthalmic (eye) drops 0.1 %, 0.15 %</i>	Tier 3	PA
<i>brimonidine ophthalmic (eye) drops 0.2 %</i>	Tier 2	
<i>brimonidine-timolol</i>	Tier 3	PA
COMBIGAN	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

Drug Name	Tier	Restrictions/Limits
IOPIDINE OPHTHALMIC (EYE) DROPPERETTE	Tier 3	PA
SIMBRINZA	Tier 2	
<b>ANTIALLERGIC AGENTS</b>		
ALAWAY	Tier 2	
ALOCRIAL	Tier 3	PA
ALOMIDE	Tier 3	PA
<i>azelastine</i>	Tier 2	
<i>azelastine-fluticasone</i>	Tier 3	PA
<i>bepotastine besilate</i>	Tier 3	PA
BEPREVE	Tier 3	PA
CHILDREN'S ALAWAY	Tier 2	
<i>cromolyn nasal</i>	Tier 1	
<i>cromolyn ophthalmic (eye)</i>	Tier 2	
DYMISTA	Tier 3	PA
<i>epinastine</i>	Tier 3	PA
EYE ITCH RELIEF	Tier 2	
<i>ketotifen fumarate</i>	Tier 3	PA
NASALCROM	Tier 1	
<i>olopatadine nasal</i>	Tier 3	PA
<i>olopatadine ophthalmic (eye)</i>	Tier 2	
PATADAY ONCE DAILY RELIEF	Tier 3	PA
PATADAY TWICE DAILY RELIEF	Tier 3	PA
PATANASE	Tier 3	PA
RYALTRIS	Tier 3	PA
ZADITOR	Tier 3	PA
ZERVIAE	Tier 3	PA
<b>ANTIBACTERIALS (52:04)</b>		
AZASITE	Tier 3	PA
<i>bacitracin ophthalmic (eye)</i>	Tier 1	
<i>bacitracin-polymyxin b</i>	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
BESIVANCE	Tier 3	PA
CILOXAN OPHTHALMIC (EYE) OINTMENT	Tier 3	PA
CIPRO HC	Tier 3	PA
CIPRO ORAL SUSPENSION,MICROCAPSULE RECON	Tier 2	
CIPRO ORAL TABLET 250 MG, 500 MG	Tier 3	PA; QL (42 tablets per 1 fill)
<i>ciprofloxacin</i>	Tier 2	
<i>ciprofloxacin hcl ophthalmic (eye)</i>	Tier 2	
<i>ciprofloxacin hcl oral</i>	Tier 2	QL (42 tablets per 1 fill)
<i>ciprofloxacin hcl otic (ear)</i>	Tier 3	PA
<i>ciprofloxacin-dexamethasone</i>	Tier 3	PA
<i>ciprofloxacin-fluocinolone</i>	Tier 3	PA
<i>doxycycline hyclate oral capsule</i>	Tier 1	
<i>doxycycline hyclate oral tablet 100 mg</i>	Tier 1	
<i>doxycycline monohydrate oral capsule 100 mg, 50 mg</i>	Tier 1	
<i>doxycycline monohydrate oral suspension for reconstitution</i>	Tier 1	
<i>doxycycline monohydrate oral tablet 100 mg, 50 mg</i>	Tier 1	
E.E.S. 400 ORAL TABLET	Tier 3	PA
E.E.S. GRANULES	Tier 3	PA
ERYPED 200	Tier 3	PA
ERYPED 400	Tier 3	PA
ERY-TAB	Tier 3	PA
ERYTHROCIN (AS STEARATE) ORAL TABLET 250 MG	Tier 2	
<i>erythromycin ethylsuccinate oral suspension for reconstitution 200 mg/5 ml</i>	Tier 2	
<i>erythromycin ethylsuccinate oral suspension for reconstitution 400 mg/5 ml</i>	Tier 3	PA
<i>erythromycin ethylsuccinate oral tablet</i>	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>erythromycin ophthalmic (eye)</i>	Tier 2	
<i>erythromycin oral</i>	Tier 3	PA
<i>gatifloxacin</i>	Tier 3	PA
<i>gentamicin ophthalmic (eye) drops</i>	Tier 1	
<i>levofloxacin oral solution</i>	Tier 2	
<i>levofloxacin oral tablet 250 mg, 500 mg</i>	Tier 2	QL (14 tablets per 1 fill)
<i>levofloxacin oral tablet 750 mg</i>	Tier 2	QL (28 tablets per 1 fill)
<i>moxifloxacin ophthalmic (eye) drops</i>	Tier 2	
<i>moxifloxacin ophthalmic (eye) drops, viscous</i>	Tier 3	PA
<i>moxifloxacin oral</i>	Tier 3	PA; QL (14 tablets per 1 fill)
<i>neomycin</i>	Tier 2	
<i>neomycin-bacitracin-poly-hc</i>	Tier 1	
<i>neomycin-bacitracin-polymyxin</i>	Tier 1	
<i>neomycin-polymyxin b-dexameth</i>	Tier 1	
<i>neomycin-polymyxin-gramicidin</i>	Tier 1	
<i>neomycin-polymyxin-hc otic (ear)</i>	Tier 1	
OCUFLOX	Tier 3	PA
<i>ofloxacin ophthalmic (eye)</i>	Tier 2	
<i>ofloxacin oral tablet 300 mg, 400 mg</i>	Tier 3	PA
<i>ofloxacin otic (ear)</i>	Tier 2	
<i>polymyxin b sulf-trimethoprim</i>	Tier 1	
<i>sulfacetamide sodium ophthalmic (eye)</i>	Tier 1	
<i>sulfacetamide-prednisolone</i>	Tier 1	
<i>tobramycin ophthalmic (eye)</i>	Tier 1	
<i>tobramycin-dexamethasone</i>	Tier 1	
VIGAMOX	Tier 3	PA
<b>ANTIGLAUCOMA AGENTS, MISCELLANEOUS</b>		
RHOPRESSA	Tier 2	
ROCKLATAN	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

Drug Name	Tier	Restrictions/Limits
<b>ANTI-INFECTIVES, MISCELLANEOUS (52:04)</b>		
<i>acetic acid otic (ear)</i>	Tier 1	
<i>hydrocortisone-acetic acid</i>	Tier 1	
<b>ANTI-INFLAMMATORY AGENTS (EENT)</b>		
CEQUA	Tier 3	PA; QL (60 ampules per 30 days)
<i>cyclosporine ophthalmic (eye)</i>	Tier 3	PA; QL (60 ampules per 30 days)
MIEBO (PF)	Tier 3	PA
OXERVATE	Tier 1	PA; QL (28 vials per 28 days); AGE (Min 2 Years)
RESTASIS	Tier 2	QL (60 ampules per 30 days)
RESTASIS MULTIDOSE	Tier 2	QL (5.5 ML per 30 days)
XIIDRA	Tier 2	QL (60 units per 30 days)
<b>ASTRINGENT(S)</b>		
<i>chlorhexidine gluconate mucous membrane</i>	Tier 1	
PAROEX ORAL RINSE	Tier 1	
<b>BETA-ADRENERGIC BLOCKING AGENTS (EENT)</b>		
<i>betaxolol</i>	Tier 3	PA
BETIMOL	Tier 3	PA
BETOPTIC S	Tier 2	
<i>brimonidine-timolol</i>	Tier 3	PA
<i>carteolol</i>	Tier 2	
COMBIGAN	Tier 2	
COSOPT	Tier 3	PA
COSOPT (PF)	Tier 3	PA
<i>dorzolamide-timolol</i>	Tier 2	
<i>dorzolamide-timolol (pf) ophthalmic (eye) dropperette</i>	Tier 3	PA
ISTALOL	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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



<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>levobunolol ophthalmic (eye) drops 0.5 %</i>	Tier 3	PA
<i>timolol maleate (pf) ophthalmic (eye) dropperette 0.5 %</i>	Tier 3	PA
<i>timolol maleate ophthalmic (eye) drops</i>	Tier 2	
<i>timolol maleate ophthalmic (eye) drops, once daily</i>	Tier 3	PA
<i>timolol maleate ophthalmic (eye) gel forming solution</i>	Tier 2	
TIMOPTIC OCUDOSE (PF)	Tier 3	PA
<b>CARBONIC ANHYDRASE INHIBITORS (EENT)</b>		
<i>acetazolamide oral capsule, extended release</i>	Tier 1	QL (2 capsules per 1 day)
<i>acetazolamide oral tablet</i>	Tier 1	QL (4 tablets per 1 day)
AZOPT	Tier 2	
<i>brinzolamide</i>	Tier 3	PA
COSOPT	Tier 3	PA
COSOPT (PF)	Tier 3	PA
<i>dorzolamide</i>	Tier 2	
<i>dorzolamide-timolol</i>	Tier 2	
<i>dorzolamide-timolol (pf) ophthalmic (eye) dropperette</i>	Tier 3	PA
SIMBRINZA	Tier 2	
<b>CORTICOSTEROIDS (EENT)</b>		
24 HOUR NASAL ALLERGY	Tier 3	PA
ALLERGY RELIEF (FLUTICASONE)	Tier 3	PA
ALREX	Tier 3	PA
ALVESCO	Tier 3	
<i>azelastine-fluticasone</i>	Tier 3	PA
<i>budesonide nasal</i>	Tier 3	PA
CHILDREN'S FLONASE ALLERGY RLF	Tier 3	PA
CIPRO HC	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>ciprofloxacin-dexamethasone</i>	Tier 3	PA
<i>ciprofloxacin-fluocinolone</i>	Tier 3	PA
<i>dexamethasone sodium phosphate ophthalmic (eye)</i>	Tier 1	
DYMISTA	Tier 3	PA
EYSUVIS	Tier 3	PA; QL (8.3 ML per 30 days)
<i>flunisolide</i>	Tier 3	PA
<i>fluorometholone</i>	Tier 1	QL (15 ML per 30 dayss)
<i>fluticasone propionate nasal</i>	Tier 2	
<i>hydrocortisone-acetic acid</i>	Tier 1	
<i>loteprednol etabonate ophthalmic (eye) drops,suspension 0.2 %</i>	Tier 3	PA
<i>mometasone nasal</i>	Tier 3	PA
NASAL ALLERGY	Tier 3	PA
NASONEX 24HR ALLERGY	Tier 3	PA
<i>neomycin-bacitracin-poly-hc</i>	Tier 1	
<i>neomycin-polymyxin b-dexameth</i>	Tier 1	
OMNARIS	Tier 3	PA
<i>prednisolone acetate</i>	Tier 1	
<i>prednisolone sodium phosphate ophthalmic (eye)</i>	Tier 1	
QNASL	Tier 3	PA
RYALTRIS	Tier 3	PA
<i>tobramycin-dexamethasone</i>	Tier 1	
<i>triamcinolone acetonide nasal</i>	Tier 3	PA
XHANCE	Tier 3	PA
ZETONNA	Tier 3	PA
<b>EENT DRUGS, MISCELLANEOUS</b>		
ARTIFICIAL TEARS (PF)	Tier 1	
ARTIFICIAL TEARS (POLYVIN ALC)	Tier 1	
ARTIFICIAL TEARS(DEXT70-HYPRO)	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

Drug Name	Tier	Restrictions/Limits
ARTIFICIAL TEARS(GLYCERIN-PEG)	Tier 1	
ARTIFICIAL TEARS(PVALCH-POVID)	Tier 1	
BABY AYR SALINE	Tier 1	
BION TEARS (PF)	Tier 1	
<i>carboxymethylcellulose sodium ophthalmic (eye) dropperette,gel</i>	Tier 1	
<i>carboxymethylcellulose sodium ophthalmic (eye) drops</i>	Tier 1	
<i>ipratropium bromide nasal</i>	Tier 2	
LUBRICANT (P-GLYCOL-GLYCERIN)	Tier 1	
LUBRICANT EYE (PG-PEG 400)	Tier 1	
LUBRICATING PLUS	Tier 1	
NATURAL TEARS (PF)	Tier 1	
<i>polyvinyl alcohol</i>	Tier 1	
REFRESH LACRI-LUBE	Tier 1	
REFRESH LIQUIGEL	Tier 1	
REFRESH P.M.	Tier 1	
<i>sodium chloride ophthalmic (eye)</i>	Tier 1	
SYSTANE (PROPYLENE GLYCOL)	Tier 1	
SYSTANE GEL OPHTHALMIC (EYE) DROPS,GEL	Tier 1	
SYSTANE ULTRA	Tier 1	
<b>EENT NONSTEROIDAL ANTI-INFLAM. AGENTS</b>		
ACULAR	Tier 3	PA
ACULAR LS	Tier 3	PA
ACUVAIL (PF)	Tier 3	PA
<i>bromfenac</i>	Tier 3	PA
BROMSITE	Tier 3	PA
<i>diclofenac sodium ophthalmic (eye)</i>	Tier 2	
<i>flurbiprofen sodium</i>	Tier 2	
ILEVRO	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>ketorolac nasal</i>	Tier 3	PA; QL (5 doses per 1 fill)
<i>ketorolac ophthalmic (eye) drops 0.4 %</i>	Tier 3	PA
<i>ketorolac ophthalmic (eye) drops 0.5 %</i>	Tier 2	
<i>ketorolac oral</i>	Tier 2	QL (21 tablets per 1 fill)
NEVANAC	Tier 3	PA
PROLENSA	Tier 3	PA
SPRIX	Tier 3	PA; QL (5 doses per 1 fill)
<b>LOCAL ANESTHETICS (EENT)</b>		
<i>lidocaine hcl mucous membrane jelly in applicator</i>	Tier 1	
LIDOCAINE VISCOUS	Tier 1	
<i>proparacaine</i>	Tier 1	
<b>MIOTICS</b>		
<i>pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %</i>	Tier 1	
<b>MYDRIATICS</b>		
<i>atropine ophthalmic (eye) drops 1 %</i>	Tier 1	
<i>atropine ophthalmic (eye) ointment</i>	Tier 1	
<i>cyclopentolate ophthalmic (eye) drops 1 %</i>	Tier 1	
<i>tropicamide</i>	Tier 1	
<b>PROSTAGLANDIN ANALOGS</b>		
<i>bimatoprost ophthalmic (eye)</i>	Tier 3	PA
IYUZEH (PF)	Tier 3	PA
<i>latanoprost</i>	Tier 2	
LUMIGAN OPHTHALMIC (EYE) DROPS 0.01 %	Tier 3	PA
ROCKLATAN	Tier 2	
<i>tafluprost (pf)</i>	Tier 3	PA
TRAVATAN Z	Tier 3	PA
<i>travoprost</i>	Tier 3	PA
VYZULTA	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

Drug Name	Tier	Restrictions/Limits
XALATAN	Tier 3	PA
XELPROS	Tier 3	PA
ZIOPTAN (PF)	Tier 3	PA
<b>RHO KINASE INHIBITORS</b>		
RHOPRESSA	Tier 2	
ROCKLATAN	Tier 2	
<b>VASOCONSTRICTORS</b>		
ALLERGY EYE (NAPHAZOLINE-PHEN)	Tier 1	
EYE ALLERGY RELIEF	Tier 1	
NAPHCON-A	Tier 1	
OPCON-A	Tier 1	
<i>phenylephrine hcl ophthalmic (eye) drops 2.5 %</i>	Tier 1	
<b>GASTROINTESTINAL DRUGS</b>		
<b>5-HT3 RECEPTOR ANTAGONISTS</b>		
AKYNZEO (NETUPITANT)	Tier 3	PA; QL (1 Box per 1 Claim)
<i>granisetron hcl oral</i>	Tier 2	QL (60 tablets per 30 days)
<i>ondansetron hcl oral solution</i>	Tier 2	QL (75 ML per 1 fill)
<i>ondansetron hcl oral tablet 4 mg, 8 mg</i>	Tier 2	QL (60 tablets per 30 days)
<i>ondansetron oral tablet, disintegrating 4 mg</i>	Tier 2	QL (60 tablets per 30 days)
<i>ondansetron oral tablet, disintegrating 8 mg</i>	Tier 2	QL (60 tablets per 30 fills)
SANCUSO	Tier 3	PA; QL (1 patch per 5 days)
<b>ANTACIDS AND ADSORBENTS</b>		
ACID GONE ANTACID	Tier 1	
ADVANCED ANTACID-ANTIGAS	Tier 1	
ALMACONE-2	Tier 1	
<i>aluminum hydroxide gel</i>	Tier 1	
ANTACID	Tier 1	
ANTACID (CALCIUM CARBONATE) ORAL TABLET, CHEWABLE 200 MG CALCIUM (500 MG)	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

Drug Name	Tier	Restrictions/Limits
ANTACID ANTI-GAS	Tier 1	
ANTACID CALCIUM	Tier 1	
ANTACID EXT STR (CALCIUM CARB)	Tier 1	
ANTACID EXTRA-STRENGTH ORAL TABLET,CHEWABLE 300 MG (750 MG)	Tier 1	
ANTACID LIQUID	Tier 1	
ANTACID M	Tier 1	
ANTACID MAXIMUM STRENGTH	Tier 1	
ANTACID PLUS ANTI-GAS	Tier 1	
ANTACID REGULAR STRENGTH	Tier 1	
ANTACID ULTRA STRENGTH ORAL TABLET,CHEWABLE 400 MG CALCIUM (1,000 MG)	Tier 1	
ANTACID-ANTIGAS	Tier 1	
ANTI-DIARRHEAL	Tier 1	
BISMUTH	Tier 1	
<i>bismuth subsalicylate oral tablet,chewable</i>	Tier 1	
CALCIUM ANTACID	Tier 1	
<i>calcium carbonate oral tablet,chewable 200 mg calcium (500 mg), 400 mg calcium (1,000 mg)</i>	Tier 1	
CAL-GEST ANTACID	Tier 1	
COMFORT GEL	Tier 1	
COMFORT GEL EXTRA STRENGTH	Tier 1	
DIARRHEA RELIEF (BISMUTH SUBS)	Tier 1	
DIOTAME	Tier 1	
FLAVOR CHEWS ANTACID	Tier 1	
FOAMING ANTACID	Tier 1	
GAVISCON ORAL SUSPENSION	Tier 1	
GERI-LANTA ORAL SUSPENSION 200-200-20 MG/5 ML	Tier 1	
GERI-MOX ANTACID-ANTIGAS	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

Drug Name	Tier	Restrictions/Limits
KAOPECTATE (BISMUTH SUBSALICY) ORAL SUSPENSION	Tier 1	
KAOPECTATE EX STR (BISMUTH SS)	Tier 1	
K-PEC ANTIDIARRHEAL (BISM SUB)	Tier 1	
MAG-AL PLUS	Tier 1	
MAG-AL PLUS EXTRA STRENGTH	Tier 1	
<i>magnesium oxide oral capsule</i>	Tier 1	
<i>magnesium oxide oral tablet 250 mg magnesium, 400 mg (241.3 mg magnesium), 400 mg magnesium, 420 mg, 500 mg magnesium</i>	Tier 1	
MAGOX	Tier 1	
MINTOX MAXIMUM STRENGTH	Tier 1	
PEPTO-BISMOL	Tier 1	
PEPTO-BISMOL MAX ST	Tier 1	
PEPTO-BISMOL TO-GO	Tier 1	
PHILLIPS	Tier 1	
PINK BISMUTH MAXIMUM STRENGTH	Tier 1	
PINK BISMUTH ORAL SUSPENSION 262 MG/15 ML	Tier 1	
PINK BISMUTH ORAL TABLET	Tier 1	
PINK BISMUTH ORAL TABLET,CHEWABLE	Tier 1	
<i>sodium bicarbonate oral</i>	Tier 1	
SOOTHE (BISMUTH SUBSALICYLATE)	Tier 1	
SOOTHE REGULAR STRENGTH	Tier 1	
STOMACH RELIEF	Tier 1	
STOMACH RELIEF MAX STRENGTH	Tier 1	
STOMACH RELIEF ORIGINAL	Tier 1	
TUMS	Tier 1	
TUMS E-X	Tier 1	
TUMS EXTRA STRENGTH SMOOTHIES	Tier 1	
TUMS FRESHERS	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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



Drug Name	Tier	Restrictions/Limits
TUMS ULTRA ORAL TABLET,CHEWABLE 400 MG CALCIUM (1,000 MG)	Tier 1	
ULTRA STRENGTH ANTACID	Tier 1	
URO-MAG	Tier 1	
<b>ANTIDIARRHEA AGENTS</b>		
ANTI-DIARRHEAL	Tier 1	
ANTI-DIARRHEAL (LOPERAMIDE) ORAL CAPSULE	Tier 1	
ANTI-DIARRHEAL (LOPERAMIDE) ORAL LIQUID	Tier 2	
ANTI-DIARRHEAL (LOPERAMIDE) ORAL TABLET	Tier 2	
BISMUTH	Tier 1	
<i>bismuth subsalicylate oral tablet,chewable</i>	Tier 1	
DIARRHEA RELIEF (BISMUTH SUBS)	Tier 1	
DIOTAME	Tier 1	
<i>diphenoxylate-atropine</i>	Tier 2	
KAOPECTATE (BISMUTH SUBSALICY) ORAL SUSPENSION	Tier 1	
KAOPECTATE EX STR (BISMUTH SS)	Tier 1	
K-PEC ANTIDIARRHEAL (BISM SUB)	Tier 1	
<i>loperamide oral capsule</i>	Tier 2	
<i>loperamide oral liquid</i>	Tier 1	
PEPTO-BISMOL	Tier 1	
PEPTO-BISMOL MAX ST	Tier 1	
PEPTO-BISMOL TO-GO	Tier 1	
PINK BISMUTH MAXIMUM STRENGTH	Tier 1	
PINK BISMUTH ORAL SUSPENSION 262 MG/15 ML	Tier 1	
PINK BISMUTH ORAL TABLET	Tier 1	
PINK BISMUTH ORAL TABLET,CHEWABLE	Tier 1	
SOOTHE (BISMUTH SUBSALICYLATE)	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
SOOTHE REGULAR STRENGTH	Tier 1	
STOMACH RELIEF	Tier 1	
STOMACH RELIEF MAX STRENGTH	Tier 1	
STOMACH RELIEF ORIGINAL	Tier 1	
VIBERZI	Tier 3	PA; QL (60 tablets per 30 days)
<b>ANTIFLATULENTS</b>		
ADVANCED ANTACID-ANTIGAS	Tier 1	
ALMACONE-2	Tier 1	
ANTACID	Tier 1	
ANTACID ANTI-GAS	Tier 1	
ANTACID LIQUID	Tier 1	
ANTACID M	Tier 1	
ANTACID MAXIMUM STRENGTH	Tier 1	
ANTACID PLUS ANTI-GAS	Tier 1	
ANTACID REGULAR STRENGTH	Tier 1	
ANTACID-ANTIGAS	Tier 1	
COMFORT GEL	Tier 1	
COMFORT GEL EXTRA STRENGTH	Tier 1	
GAS RELIEF (SIMETHICONE) ORAL TABLET,CHEWABLE	Tier 1	
GAS RELIEF 80 (SIMETHICONE)	Tier 1	
GAS RELIEF EXTRA STRENGTH ORAL TABLET,CHEWABLE	Tier 1	
GAS-X EXTRA STRENGTH ORAL TABLET,CHEWABLE	Tier 1	
GERI-LANTA ORAL SUSPENSION 200-200-20 MG/5 ML	Tier 1	
GERI-MOX ANTACID-ANTIGAS	Tier 1	
INFANTS GAS RELIEF ORAL DROPS,SUSPENSION	Tier 1	
MAG-AL PLUS	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

Drug Name	Tier	Restrictions/Limits
MAG-AL PLUS EXTRA STRENGTH	Tier 1	
MINTOX MAXIMUM STRENGTH	Tier 1	
<i>simethicone oral tablet, chewable</i>	Tier 1	
<b>ANTI-HISTAMINES (GI DRUGS)</b>		
<i>dimenhydrinate oral</i>	Tier 1	
<i>meclizine oral tablet 12.5 mg, 25 mg</i>	Tier 1	
<i>meclizine oral tablet, chewable</i>	Tier 1	
<i>prochlorperazine</i>	Tier 1	QL (2 suppositories per 1 day)
<i>prochlorperazine maleate</i>	Tier 1	QL (4 tablets per 1 day)
<b>ANTI-INFLAMMATORY AGENTS (GI DRUGS)</b>		
<i>alosetron</i>	Tier 3	PA
APRISO	Tier 2	
AZULFIDINE	Tier 3	PA
AZULFIDINE EN-TABS	Tier 3	PA
<i>balsalazide</i>	Tier 3	PA
COLAZAL	Tier 3	PA
DELZICOL	Tier 3	PA
DIPENTUM	Tier 3	PA
LIALDA	Tier 2	
LOTRONEX	Tier 3	PA
<i>mesalamine oral</i>	Tier 3	PA
<i>mesalamine rectal enema</i>	Tier 1	
PENTASA	Tier 3	PA
<i>sulfasalazine</i>	Tier 2	
<b>ANTIULCER AGENTS AND ACID SUPPRESS., MISC</b>		
<i>bismuth subcit k-metronidz-tcn</i>	Tier 3	PA
PYLERA	Tier 2	
TALICIA	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

Drug Name	Tier	Restrictions/Limits
<b>ANTIULCER AGENTS AND ACID SUPPRESSANTS</b>		
<i>amoxicillin oral capsule</i>	Tier 1	
<i>amoxicillin oral suspension for reconstitution</i>	Tier 1	
<i>amoxicillin oral tablet</i>	Tier 1	
<i>amoxicillin oral tablet, chewable 125 mg, 250 mg</i>	Tier 1	
<i>amoxicillin-pot clavulanate oral suspension for reconstitution</i>	Tier 1	
<i>amoxicillin-pot clavulanate oral tablet</i>	Tier 1	
<i>amoxicillin-pot clavulanate oral tablet, chewable</i>	Tier 1	
FLAGYL ORAL CAPSULE	Tier 3	PA
LIKMEZ	Tier 3	PA
<i>metronidazole oral capsule</i>	Tier 3	PA
<i>metronidazole oral tablet</i>	Tier 2	
<b>CATHARTICS AND LAXATIVES</b>		
ALOPHEN (BISACODYL)	Tier 1	
<i>bisacodyl</i>	Tier 1	
CITRATE OF MAGNESIA	Tier 1	
CITROMA	Tier 1	
COLACE CLEAR	Tier 1	
CORRECTOL	Tier 1	
DAILY FIBER (PSYLLIUM-SUCROSE) ORAL POWDER 3.4 GRAM/7 GRAM	Tier 1	
DOCUPRENE	Tier 1	
<i>docusate calcium</i>	Tier 1	
<i>docusate sodium oral capsule</i>	Tier 1	
<i>docusate sodium oral liquid</i>	Tier 1	
<i>docusate sodium oral tablet</i>	Tier 1	
<i>docusate sodium rectal</i>	Tier 1	
DOK	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

Drug Name	Tier	Restrictions/Limits
DULCOLAX (BISACODYL) ORAL	Tier 1	
ENEMA	Tier 1	
ENEMA DISPOSABLE	Tier 1	
ENEMEEZ PLUS	Tier 1	
EX-LAX (SENNOSIDES) ORAL TABLET	Tier 1	
EX-LAX MAXIMUM STRENGTH	Tier 1	
FIBER (PSYLLIUM HUSK-SUGAR) ORAL POWDER 3.4 GRAM/7 GRAM	Tier 1	
FIBER (WITH ASPARTAME) ORAL POWDER 3.4 GRAM/5.8 GRAM	Tier 1	
FLEET ENEMA	Tier 1	
FLEET MINERAL OIL	Tier 1	
GENTLE LAXATIVE (BISACODYL) ORAL	Tier 1	
GERI-KOT	Tier 1	
GERI-MUCIL (ASPARTAME)	Tier 1	
LAXATIVE (BISACODYL) ORAL	Tier 1	
LAXATIVE (SENNOSIDES)	Tier 1	
LAXATIVE PEG 3350	Tier 1	
LAXATIVE PILLS	Tier 1	
LAXATIVE PILLS REGULAR	Tier 1	
<i>magnesium citrate oral solution</i>	Tier 1	
<i>magnesium hydroxide oral suspension 400 mg/5 ml</i>	Tier 1	
METAMUCIL (SUGAR)	Tier 1	
METAMUCIL (WITH SUGAR) ORAL POWDER 3.4 GRAM/7 GRAM	Tier 1	
METAMUCIL MULTIHEALTH FIBER	Tier 1	
METAMUCIL SUGAR-FREE (ASPART)	Tier 1	
MILK OF MAGNESIA	Tier 1	
<i>mineral oil rectal</i>	Tier 1	
NATURAL DAILY FIBER	Tier 1	
NATURAL FIBER LAXATIVE (SUGAR)	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

Drug Name	Tier	Restrictions/Limits
NATURAL FIBER LAXATIVE(ASPART)	Tier 1	
NATURAL SENNA LAXATIVE	Tier 1	
NATURAL VEG LAXATIVE(SENNOSID)	Tier 1	
P-COL RITE	Tier 1	
PEDIATRIC ENEMA	Tier 1	
<i>peg 3350-electrolytes</i>	Tier 1	
<i>peg-electrolyte soln</i>	Tier 1	
PERDIEM OVERNIGHT RELIEF	Tier 1	
PHILLIPS MILK OF MAGNESIA ORAL SUSPENSION	Tier 1	
<i>polyethylene glycol 3350 oral powder</i>	Tier 1	
PROMOLAXIN	Tier 1	
READY-TO-USE ENEMA	Tier 1	
READY-TO-USE ENEMA (MIN OIL)	Tier 1	
SENXON-S	Tier 1	
SENNALAX	Tier 1	
SENNALAXATIVE	Tier 1	
SENNALAX ORAL CAPSULE	Tier 1	
SENNALAX ORAL SYRUP 8.8 MG/5 ML	Tier 1	
SENNALAX ORAL TABLET	Tier 1	
SENNALAX PLUS ORAL TABLET	Tier 1	
SENNALAX WITH DOCUSATE SODIUM	Tier 1	
SENNALAX-S	Tier 1	
SENNALAX-TIME S	Tier 1	
<i>sennosides oral syrup</i>	Tier 1	
<i>sennosides-docusate sodium</i>	Tier 1	
SENOKOT EXTRA STRENGTH	Tier 1	
SENOKOT ORAL TABLET	Tier 1	
SENOKOT-S	Tier 1	
<i>sodium,potassium,mag sulfates</i>	Tier 1	
STIMULANT LAXATIVE PLUS	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

Drug Name	Tier	Restrictions/Limits
STOOL SOFTENER ORAL CAPSULE 50 MG	Tier 1	
STOOL SOFTENER ORAL TABLET	Tier 1	
STOOL SOFTENER-LAXATIVE	Tier 1	
STOOL SOFTENER-STIMULANT LAXAT ORAL TABLET	Tier 1	
VEGETABLE LAXATIVE	Tier 1	
WAL-MUCIL FIBER (ASPARTAME)	Tier 1	
WAL-MUCIL FIBER (SUGAR)	Tier 1	
WOMAN'S LAXATIVE (BISACODYL)	Tier 1	
WOMEN'S GENTLE LAXATIVE(BISAC)	Tier 1	
WOMEN'S LAXATIVE (BISACODYL) ORAL TABLET	Tier 1	
<b>CHLORIDE CHANNEL ACTIVATORS</b>		
AMITIZA	Tier 2	
<i>lubiprostone</i>	Tier 3	PA
<b>CHOLELITHOLYTIC AGENTS</b>		
RELTONE	Tier 3	PA
URSO 250	Tier 3	PA
URSO FORTE	Tier 3	PA
<i>ursodiol oral capsule 300 mg</i>	Tier 2	
<i>ursodiol oral tablet</i>	Tier 2	
<b>DIGESTANTS</b>		
CREON	Tier 2	PA
PERTZYE	Tier 3	PA
VIOKACE	Tier 3	PA
ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 10,000-32,000 -42,000 UNIT, 15,000-47,000 -63,000 UNIT, 20,000-63,000- 84,000 UNIT, 25,000-79,000-105,000 UNIT, 3,000-10,000 -14,000-UNIT, 40,000-126,000- 168,000 UNIT, 5,000-17,000- 24,000 UNIT	Tier 2	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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



Drug Name	Tier	Restrictions/Limits
<b>GI DRUGS, MISCELLANEOUS</b>		
CULTURELLE ORAL CAPSULE, SPRINKLE	Tier 1	
<i>dronabinol</i>	Tier 1	PA
IBSRELA	Tier 3	PA; QL (2 tablets per 1 day); AGE (Min 18 Years)
<i>orlistat</i>	Tier 2	PA; AGE (Min 12 Years)
XENICAL	Tier 2	PA; AGE (Min 12 Years)
<b>GUANYLATE CYCLASE C (GCC) RECEPT AGONIST</b>		
LINZESS	Tier 2	
TRULANCE	Tier 3	PA
<b>HISTAMINE H2-ANTAGONISTS</b>		
<i>cimetidine</i>	Tier 1	
DUEXIS	Tier 3	PA
<i>famotidine oral suspension for reconstitution</i>	Tier 1	QL (5 ML per 1 day); AGE (Max 6 Years)
<i>famotidine oral tablet</i>	Tier 1	
<i>ibuprofen-famotidine</i>	Tier 3	PA
<b>IMMUNOMODULATORY AGENTS (56:44)</b>		
VELSIPITY	Tier 3	PA
<b>LIPOTROPIC AGENTS</b>		
ALGAL OMEGA-3 DHA	Tier 1	
PRENATAL DHA	Tier 1	
<b>NEUROKININ-1 RECEPTOR ANTAGONISTS</b>		
AKYNZEO (NETUPITANT)	Tier 3	PA; QL (1 Box per 1 Claim)
<i>aprepitant oral capsule 125 mg, 40 mg</i>	Tier 3	PA; QL (1 capsule per 1 fill); AGE (Min 12 Years)
<i>aprepitant oral capsule 80 mg</i>	Tier 3	PA; QL (2 capsules per 1 fill); AGE (Min 12 Years)
<i>aprepitant oral capsule, dose pack</i>	Tier 3	PA; QL (3 capsules per 1 fill); AGE (Min 12 Years)

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
EMEND ORAL CAPSULE 80 MG	Tier 2	QL (2 capsules per 1 fill); AGE (Min 12 Years)
EMEND ORAL CAPSULE,DOSE PACK	Tier 3	PA; QL (3 capsules per 1 fill); AGE (Min 12 Years)
EMEND ORAL SUSPENSION FOR RECONSTITUTION	Tier 3	PA; QL (1 ML per 30 days); AGE (Min 12 Years)
<b>OPIOID ANTAGONISTS</b>		
MOVANTIK	Tier 3	PA
RELISTOR ORAL	Tier 3	PA
RELISTOR SUBCUTANEOUS SOLUTION	Tier 3	PA
RELISTOR SUBCUTANEOUS SYRINGE	Tier 3	PA
SYMPROIC	Tier 3	PA
<b>POTASSIUM-COMPETITIVE ACID BLOCKERS</b>		
<i>amoxicillin oral capsule</i>	Tier 1	
<i>amoxicillin oral suspension for reconstitution</i>	Tier 1	
<i>amoxicillin oral tablet</i>	Tier 1	
<i>amoxicillin oral tablet,chewable 125 mg, 250 mg</i>	Tier 1	
<i>amoxicillin-pot clavulanate oral suspension for reconstitution</i>	Tier 1	
<i>amoxicillin-pot clavulanate oral tablet</i>	Tier 1	
<i>amoxicillin-pot clavulanate oral tablet,chewable</i>	Tier 1	
<b>PROKINETIC AGENTS</b>		
<i>metoclopramide hcl oral solution</i>	Tier 1	
<i>metoclopramide hcl oral tablet</i>	Tier 1	
MOTEGRITY	Tier 3	PA
<b>PROSTAGLANDINS</b>		
ARTHROTEC 50	Tier 3	PA
ARTHROTEC 75	Tier 3	PA
<i>diclofenac-misoprostol</i>	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>misoprostol</i>	Tier 1	QL (4 tablets per 1 day)
<b>PROTECTANTS</b>		
<i>sucralfate oral tablet</i>	Tier 1	QL (4 tablets per 1 day)
<b>PROTON-PUMP INHIBITORS</b>		
ACID REDUCER (OMEPRAZOLE)	Tier 3	PA
ACIPHEX	Tier 3	PA
ACIPHEX SPRINKLE	Tier 3	PA
<i>amoxicil-clarithromy-lansopraz</i>	Tier 3	PA; QL (224 capsules per 1 fill)
DEXILANT	Tier 3	PA
<i>dexlansoprazole</i>	Tier 3	PA
<i>esomeprazole magnesium oral capsule, delayed release (dr/ec)</i>	Tier 3	PA
<i>esomeprazole magnesium oral granules dr for susp in packet</i>	Tier 3	PA; QL (2 packets per 1 day)
<i>esomeprazole magnesium oral tablet, delayed release (dr/ec)</i>	Tier 3	PA
KONVOMEF	Tier 3	PA
<i>lansoprazole</i>	Tier 3	PA
<i>naproxen-esomeprazole</i>	Tier 3	PA
NEXIUM	Tier 3	PA
NEXIUM PACKET	Tier 2	QL (2 packets per 1 day)
OMECLAMOX-PAK	Tier 3	PA
<i>omeprazole magnesium</i>	Tier 3	PA
<i>omeprazole oral capsule, delayed release (dr/ec)</i>	Tier 2	QL (2 capsules per 1 day)
<i>omeprazole oral tablet, delayed release (dr/ec)</i>	Tier 3	PA
<i>omeprazole oral tablet, disintegrat, delay rel</i>	Tier 3	PA
<i>omeprazole-sodium bicarbonate</i>	Tier 3	PA
<i>pantoprazole oral granules dr for susp in packet</i>	Tier 3	PA; QL (2 packets per 1 day)

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>pantoprazole oral tablet, delayed release (dr/ec)</i>	Tier 2	QL (2 tablets per 1 day)
PREVACID 24HR	Tier 3	PA
PREVACID ORAL CAPSULE, DELAYED RELEASE (DR/EC) 30 MG	Tier 3	PA
PREVACID SOLUTAB	Tier 3	PA
PRILOSEC ORAL SUSP, DELAYED RELEASE FOR RECON	Tier 3	PA
PROTONIX ORAL GRANULES DR FOR SUSP IN PACKET	Tier 2	QL (2 packets per 1 day)
PROTONIX ORAL TABLET, DELAYED RELEASE (DR/EC)	Tier 2	QL (2 tablets per 1 day)
<i>rabeprazole oral tablet, delayed release (dr/ec)</i>	Tier 3	PA
TALICIA	Tier 3	PA
VIMOVO	Tier 3	PA
YOSPRALA	Tier 3	PA
ZEGERID	Tier 3	PA
<b>HEAVY METAL ANTAGONISTS</b>		
<b>HEAVY METAL ANTAGONISTS</b>		
CHEMET	Tier 1	
<b>HORMONES AND SYNTHETIC SUBSTITUTES</b>		
<b>ADRENALS</b>		
ADVAIR DISKUS	Tier 2	QL (3 Inhalers per 90 days)
ADVAIR HFA	Tier 2	QL (1 inhaler per 30 days)
AIRDUO DIGIHALER	Tier 3	PA; QL (1 inhaler per 30 days)
AIRDUO RESPICLICK	Tier 3	PA; QL (1 inhaler per 30 days)
AIRSUPRA	Tier 3	PA
ALKINDI SPRINKLE	Tier 1	
ALVESCO	Tier 3	
ARMONAIR DIGIHALER	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
ARNUIITY ELLIPTA	Tier 3	PA
ASMANEX HFA	Tier 3	PA; QL (3 inhalers per 90 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG/ ACTUATION (30)	Tier 2	QL (1 inhaler per 30 days); AGE (Max 11 Years)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 220 MCG/ ACTUATION (120), 220 MCG/ ACTUATION (14), 220 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (60)	Tier 2	QL (1 inhaler per 30 days)
BREO ELLIPTA INHALATION BLISTER WITH DEVICE 100-25 MCG/DOSE, 200-25 MCG/DOSE	Tier 3	PA; QL (60 blisters per 30 days)
BREO ELLIPTA INHALATION BLISTER WITH DEVICE 50-25 MCG/DOSE	Tier 3	PA; QL (60 EA per 30 days)
BREYNA	Tier 3	PA
<i>budesonide inhalation</i>	Tier 2	QL (2 respules per 1 day)
<i>budesonide oral capsule, delayed, extend. release</i>	Tier 1	PA; QL (16 weeks per 4 months)
<i>budesonide oral tablet, delayed and ext. release</i>	Tier 3	PA
<i>budesonide-formoterol</i>	Tier 3	PA; QL (2 inhalers per 30 days)
<i>dexamethasone oral elixir</i>	Tier 1	
<i>dexamethasone oral solution</i>	Tier 1	
<i>dexamethasone oral tablet</i>	Tier 1	
<i>dexamethasone sodium phos (pf) injection syringe</i>	Tier 1	
<i>dexamethasone sodium phosphate injection syringe</i>	Tier 1	
DULERA INHALATION HFA AEROSOL INHALER 100-5 MCG/ACTUATION, 50-5 MCG/ACTUATION	Tier 2	QL (3 inhalers per 90 days)
DULERA INHALATION HFA AEROSOL INHALER 200-5 MCG/ACTUATION	Tier 2	QL (3 Inhalers per 90 days)
EMFLAZA	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>fludrocortisone</i>	Tier 1	
<i>fluticasone furoate-vilanterol</i>	Tier 3	PA; QL (60 blisters per 30 days)
<i>fluticasone propionate inhalation blister with device</i>	Tier 3	PA
<i>fluticasone propionate inhalation hfa aerosol inhaler 110 mcg/actuation, 44 mcg/actuation</i>	Tier 3	PA; QL (3 inhalers per 90 days)
<i>fluticasone propionate inhalation hfa aerosol inhaler 220 mcg/actuation</i>	Tier 3	PA; QL (6 inhalers per 90 days)
<i>fluticasone propion-salmeterol inhalation aerosol powdr breath activated</i>	Tier 3	PA; QL (1 inhaler per 30 dayss)
<i>fluticasone propion-salmeterol inhalation blister with device</i>	Tier 3	PA; QL (60 blisters per 30 dayss)
<i>fluticasone propion-salmeterol inhalation hfa aerosol inhaler</i>	Tier 3	PA; QL (1 inhaler per 30 days)
HEMADY	Tier 1	
<i>hydrocortisone oral</i>	Tier 1	
<i>methylprednisolone</i>	Tier 1	
OMNARIS	Tier 3	PA
<i>prednisolone oral solution</i>	Tier 1	
<i>prednisolone sodium phosphate oral solution 15 mg/5 ml (3 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)</i>	Tier 1	
<i>prednisone</i>	Tier 1	
PULMICORT	Tier 3	PA; QL (2 respules per 1 day)
PULMICORT FLEXHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 180 MCG/ACTUATION	Tier 3	PA; QL (6 inhalers per 90 days)
PULMICORT FLEXHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 90 MCG/ACTUATION	Tier 3	PA; QL (3 inhalers per 90 days)
QVAR REDIHALER	Tier 3	PA
SYMBICORT	Tier 2	QL (2 inhalers per 30 days)

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

Drug Name	Tier	Restrictions/Limits
TAPERDEX ORAL TABLETS,DOSE PACK 1.5 MG (27 TABS), 1.5 MG (49 TABS)	Tier 1	
UCERIS ORAL	Tier 3	PA
WIXELA INHUB	Tier 3	PA; QL (60 blisters per 30 days)
ZETONNA	Tier 3	PA
<b>ALPHA-GLUCOSIDASE INHIBITORS</b>		
<i>acarbose</i>	Tier 2	
<i>miglitol</i>	Tier 2	
PRECOSE	Tier 3	PA
<b>AMYLINOMIMETICS</b>		
SYMLINPEN 120	Tier 2	
SYMLINPEN 60	Tier 2	
<b>ANDROGENS</b>		
ANDRODERM	Tier 3	PA
ANDROGEL	Tier 3	PA
<i>danazol</i>	Tier 1	
FORTESTA	Tier 3	PA
NATESTO	Tier 3	PA
TESTIM	Tier 3	PA
<i>testosterone cypionate</i>	Tier 1	
<i>testosterone transdermal gel</i>	Tier 3	PA
<i>testosterone transdermal gel in metered-dose pump 10 mg/0.5 gram /actuation, 12.5 mg/ 1.25 gram (1 %)</i>	Tier 3	PA
<i>testosterone transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)</i>	Tier 2	PA
<i>testosterone transdermal gel in packet</i>	Tier 3	PA
<i>testosterone transdermal solution in metered pump w/app</i>	Tier 3	PA
VOGELXO	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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



Drug Name	Tier	Restrictions/Limits
<b>ANTIDIABETIC AGENTS, MISCELLANEOUS</b>		
<i>colesevelam</i>	Tier 3	PA
WELCHOL	Tier 3	PA
<b>ANTIESTROGENS</b>		
<i>anastrozole</i>	Tier 1	
<i>exemestane</i>	Tier 1	
KISQALI FEMARA CO-PACK	Tier 1	
<i>letrozole</i>	Tier 1	
<b>ANTIGONADTROPINS</b>		
MYFEMBREE	Tier 2	PA; QL (28 EA per 28 days); AGE (Min 18 Years)
ORGOVYX	Tier 1	
ORIAHNN	Tier 2	PA; QL (56 EA per 28 days); AGE (Min 18 Years)
ORLISSA ORAL TABLET 150 MG	Tier 1	PA; QL (28 EA per 28 days); AGE (Min 18 Years)
ORLISSA ORAL TABLET 200 MG	Tier 1	PA; QL (56 EA per 28 days); AGE (Min 18 Years)
<b>ANTIHYPOGLYCEMIC AGENTS, MISCELLANEOUS</b>		
<i>diazoxide</i>	Tier 3	PA
PROGLYCEM	Tier 2	
<b>ANTIPARATHYROID AGENTS</b>		
<i>calcitonin (salmon) nasal</i>	Tier 2	
<i>cinacalcet oral tablet 30 mg, 60 mg</i>	Tier 1	PA; QL (2 tablets per 1 day)
<i>cinacalcet oral tablet 90 mg</i>	Tier 1	PA; QL (4 tablets per 1 day)
<b>ANTITHYROID AGENTS</b>		
<i>methimazole oral tablet 10 mg, 5 mg</i>	Tier 1	
<i>propylthiouracil</i>	Tier 1	
<b>BIGUANIDES</b>		
ACTOPLUS MET ORAL TABLET 15-850 MG	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>alogliptin-metformin</i>	Tier 3	PA
<i>dapaglifloz propaned-metformin</i>	Tier 3	PA
<i>glipizide-metformin</i>	Tier 3	PA
GLUMETZA	Tier 3	PA
<i>glyburide-metformin</i>	Tier 2	
INVOKAMET	Tier 2	
INVOKAMET XR	Tier 3	PA
JANUMET	Tier 2	QL (2 tablets per 1 day)
JANUMET XR	Tier 2	
JENTADUETO	Tier 2	
JENTADUETO XR	Tier 3	PA
KAZANO	Tier 3	PA
<i>metformin oral solution</i>	Tier 3	PA
<i>metformin oral tablet</i>	Tier 2	
<i>metformin oral tablet extended release 24 hr</i>	Tier 2	
<i>metformin oral tablet extended release 24hr</i>	Tier 3	PA
<i>metformin oral tablet,er gast.retention 24 hr</i>	Tier 3	PA
<i>pioglitazone-metformin</i>	Tier 3	PA
RIOMET	Tier 3	PA
RIOMET ER	Tier 3	PA
<i>saxagliptin-metformin</i>	Tier 3	PA
SEGLUROMET	Tier 3	PA
SYNJARDY	Tier 2	
SYNJARDY XR	Tier 3	PA
TRIJARDY XR	Tier 3	PA
XIGDUO XR	Tier 2	
<b>CONTRACEPTIVES</b>		
AFTERA	Tier 1	
ALYACEN 1/35 (28)	Tier 1	
ALYACEN 7/7/7 (28)	Tier 1	
APRI	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

Drug Name	Tier	Restrictions/Limits
ARANELLE (28)	Tier 1	
AVIANE	Tier 1	
AZURETTE (28)	Tier 1	
BLISOVI 24 FE	Tier 1	
BLISOVI FE 1.5/30 (28)	Tier 1	
BLISOVI FE 1/20 (28)	Tier 1	
BRIELLYN	Tier 1	
CAMILA	Tier 1	
CAZANT (28)	Tier 1	
CRYSELLE (28)	Tier 1	
DASETTA 1/35 (28)	Tier 1	
DASETTA 7/7/7 (28)	Tier 1	
DEBLITANE	Tier 1	
<i>desog-e.estradiol/e.estradiol</i>	Tier 1	
<i>desogestrel-ethinyl estradiol</i>	Tier 1	
<i>drospirenone-ethinyl estradiol</i>	Tier 1	
ECONTRA EZ	Tier 1	
ELINEST	Tier 1	
ELLA	Tier 1	
ELURYNG	Tier 1	QL (3 rings per 84 days)
ENPRESSE	Tier 1	
ENSKYCE	Tier 1	
ERRIN	Tier 1	
ESTARYLLA	Tier 1	
<i>ethynodiol diac-eth estradiol oral tablet 1-50 mg-mcg</i>	Tier 1	
<i>etonogestrel-ethinyl estradiol</i>	Tier 1	QL (3 rings per 84 days)
FALMINA (28)	Tier 1	
HEATHER	Tier 1	
ISIBLOOM	Tier 1	
JENCYCLA	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

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

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
NORTREL 1/35 (28)	Tier 1	
OPCICON ONE-STEP	Tier 1	
PHILITH	Tier 1	
PIMTREA (28)	Tier 1	
PORTIA 28	Tier 1	
RECLIPSEN (28)	Tier 1	
SETLAKIN	Tier 1	
SHAROBEL	Tier 1	
SPRINTEC (28)	Tier 1	
SRONYX	Tier 1	
TAKE ACTION	Tier 1	
TARINA FE 1/20 (28)	Tier 1	
TRI-ESTARYLLA	Tier 1	
TRI-LEGEST FE	Tier 1	
TRI-LINYAH	Tier 1	
TRI-LO-MARZIA	Tier 1	
TRI-LO-SPRINTEC	Tier 1	
TRI-SPRINTEC (28)	Tier 1	
TRIVORA (28)	Tier 1	
TRI-VYLIBRA LO	Tier 1	
VELIVET TRIPHASIC REGIMEN (28)	Tier 1	
VESTURA (28)	Tier 1	
VYFEMLA (28)	Tier 1	
WERA (28)	Tier 1	
XULANE	Tier 1	QL (9 patches per 84 dayss)
ZAFEMY	Tier 1	QL (9 patches per 84 days)
ZARAH	Tier 1	
<b>DIPEPTIDYL PEPTIDASE-4(DPP-4) INHIBITORS</b>		
<i>alogliptin</i>	Tier 3	PA
<i>alogliptin-metformin</i>	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>alogliptin-pioglitazone oral tablet 12.5-30 mg, 25-15 mg, 25-30 mg, 25-45 mg</i>	Tier 3	PA
GLYXAMBI	Tier 2	PA
JANUMET	Tier 2	QL (2 tablets per 1 day)
JANUMET XR	Tier 2	
JANUVIA	Tier 2	QL (2 tablets per 1 day)
JENTADUETO	Tier 2	
JENTADUETO XR	Tier 3	PA
KAZANO	Tier 3	PA
NESINA	Tier 3	PA
ONGLYZA ORAL TABLET 5 MG	Tier 3	PA
OSENI ORAL TABLET 12.5-30 MG, 25-15 MG, 25-30 MG, 25-45 MG	Tier 3	PA
QTERN	Tier 3	PA
<i>saxagliptin</i>	Tier 3	PA
<i>saxagliptin-metformin</i>	Tier 3	PA
STEGLUJAN	Tier 3	PA
TRADJENTA	Tier 2	
TRIJARDY XR	Tier 3	PA
<b>ESTROGEN AGONIST-ANTAGONISTS</b>		
EVISTA	Tier 3	PA
<i>raloxifene</i>	Tier 2	
<i>tamoxifen</i>	Tier 1	
<i>toremifene</i>	Tier 1	
<b>ESTROGENS</b>		
DELESTROGEN	Tier 1	
<i>estradiol oral</i>	Tier 1	AGE (Max 64 Years)
<i>estradiol transdermal patch semiweekly</i>	Tier 1	QL (8 patches per 28 dayss); AGE (Max 64 Years)
<i>estradiol transdermal patch weekly</i>	Tier 1	QL (4 patches per 28 dayss); AGE (Max 64 Years)
<i>estradiol vaginal cream</i>	Tier 1	QL (42.5 GM per 30 dayss)

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>estradiol vaginal tablet</i>	Tier 1	
<i>estradiol valerate intramuscular oil 20 mg/ml, 40 mg/ml</i>	Tier 1	
<i>estradiol-norethindrone acet</i>	Tier 1	AGE (Max 64 Years)
MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG	Tier 1	AGE (Max 64 Years)
MYFEMBREE	Tier 2	PA; QL (28 EA per 28 days); AGE (Min 18 Years)
<i>norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg</i>	Tier 1	QL (1 tablet per 1 day); AGE (Max 64 Years)
<i>norethindrone ac-eth estradiol oral tablet 1-5 mg-mcg</i>	Tier 1	AGE (Max 64 Years)
ORIAHNN	Tier 2	PA; QL (56 EA per 28 days); AGE (Min 18 Years)
PREMARIN ORAL	Tier 1	QL (1 tablet per 1 day); AGE (Max 64 Years)
PREMPHASE	Tier 1	QL (1 tablet per 1 day); AGE (Max 64 Years)
PREMPRO	Tier 1	QL (1 tablet per 1 day); AGE (Max 64 Years)
VAGIFEM	Tier 1	
YUVAFEM	Tier 1	
<b>GLYCOGENOLYTIC AGENTS</b>		
BAQSIMI	Tier 2	QL (2 Devices per 30 days)
GLUCAGEN HYPOKIT	Tier 2	
GLUCAGON (HCL) EMERGENCY KIT	Tier 3	PA; QL (6 EA per 1 Fill)
GLUCAGON EMERGENCY KIT (HUMAN)	Tier 2	QL (6 EA per 1 Fill)
GVOKE	Tier 3	PA; QL (0.4 ML per 30 days)
GVOKE HYPOPEN 1-PACK	Tier 2	QL (2 syringes per 30 days)
GVOKE HYPOPEN 2-PACK	Tier 2	QL (2 syringes per 30 days)
GVOKE PFS 1-PACK SYRINGE SUBCUTANEOUS SYRINGE 1 MG/0.2 ML	Tier 3	PA; QL (2 syringes per 30 days)

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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



Drug Name	Tier	Restrictions/Limits
GVOKE PFS 2-PACK SYRINGE SUBCUTANEOUS SYRINGE 1 MG/0.2 ML	Tier 3	PA; QL (2 syringes per 30 days)
ZEGALOGUE AUTOINJECTOR	Tier 2	
ZEGALOGUE SYRINGE	Tier 2	
<b>GONADOTROPINS</b>		
CAMCEVI (6 MONTH)	Tier 1	
<i>leuprolide (3 month)</i>	Tier 1	
<i>leuprolide subcutaneous kit</i>	Tier 1	
<b>INCRETIN MIMETICS</b>		
BYDUREON BCISE	Tier 3	PA; QL (3.4 ML per 28 days)
BYETTA SUBCUTANEOUS PEN INJECTOR 10 MCG/DOSE(250 MCG/ML) 2.4 ML	Tier 2	QL (2.4 ML per 30 days)
BYETTA SUBCUTANEOUS PEN INJECTOR 5 MCG/DOSE (250 MCG/ML) 1.2 ML	Tier 2	QL (1.2 ML per 30 days)
MOUNJARO	Tier 3	PA; QL (2 ML per 28 days)
OZEMPIC SUBCUTANEOUS PEN INJECTOR 0.25 MG OR 0.5 MG (2 MG/3 ML), 1 MG/DOSE (4 MG/3 ML), 2 MG/DOSE (8 MG/3 ML)	Tier 3	PA; QL (3 ML per 28 days)
RYBELSUS	Tier 3	PA; QL (1 EA per 1 day)
SAXENDA	Tier 1	PA; AGE (Min 18 Years)
SOLIQUA 100/33	Tier 3	PA; QL (15 ML per 28 days)
TRULICITY	Tier 2	PA; QL (4 Pens per 28 days)
VICTOZA 2-PAK	Tier 2	PA; QL (6 ML per 30 days)
VICTOZA 3-PAK	Tier 2	PA; QL (9 ML per 30 days)
WEGOVY	Tier 2	PA; AGE (Min 12 Years)
XULTOPHY 100/3.6	Tier 3	PA; QL (15 ML per 30 days)
ZEPBOUND	Tier 2	PA
<b>INSULINS</b>		
ADMELOG SOLOSTAR U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
ADMELOG U-100 INSULIN LISPRO	Tier 3	PA; QL (90 ML per 1 fill)

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

Drug Name	Tier	Restrictions/Limits
AFREZZA	Tier 3	PA; QL (180 cartridges per 1 fill)
APIDRA SOLOSTAR U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)
APIDRA U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)
BASAGLAR KWIKPEN U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
BASAGLAR TEMPO PEN(U-100)INSLN	Tier 3	PA; QL (90 ML per 1 fill)
FIASP FLEXTOUCH U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
FIASP PENFILL U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
FIASP PUMPCART	Tier 3	PA; QL (90 ML per 1 Fill)
FIASP U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
HUMALOG JUNIOR KWIKPEN U-100	Tier 2	QL (90 ML per 1 fill)
HUMALOG KWIKPEN INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML	Tier 2	QL (90 ML per 1 fill)
HUMALOG KWIKPEN INSULIN SUBCUTANEOUS INSULIN PEN 200 UNIT/ML (3 ML)	Tier 3	PA; QL (90 ML per 1 fill)
HUMALOG MIX 50-50 INSULN U-100	Tier 2	QL (90 ML per 1 fill)
HUMALOG MIX 50-50 KWIKPEN	Tier 2	QL (90 ML per 1 fill)
HUMALOG MIX 75-25 KWIKPEN	Tier 2	QL (90 ML per 1 fill)
HUMALOG MIX 75-25(U-100)INSULN	Tier 2	QL (90 ML per 1 fill)
HUMALOG TEMPO PEN(U-100)INSULN	Tier 2	QL (90 ML per 1 fill)
HUMALOG U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)
HUMULIN 70/30 U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)
HUMULIN 70/30 U-100 KWIKPEN	Tier 2	QL (90 ML per 1 fill)
HUMULIN N NPH INSULIN KWIKPEN	Tier 3	PA; QL (90 ML per 1 fill)
HUMULIN N NPH U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)
HUMULIN R REGULAR U-100 INSULN	Tier 2	QL (90 ML per 1 fill)
HUMULIN R U-500 (CONC) INSULIN	Tier 2	QL (90 ML per 1 fill)
HUMULIN R U-500 (CONC) KWIKPEN	Tier 2	QL (90 ML per 1 fill)
<i>insulin asp prt-insulin aspart</i>	Tier 2	QL (90 ML per 1 fill)
<i>insulin aspart u-100 subcutaneous cartridge</i>	Tier 3	PA; QL (90 ML per 1 fill)

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>insulin aspart u-100 subcutaneous insulin pen</i>	Tier 2	QL (90 ML per 1 fill)
<i>insulin aspart u-100 subcutaneous solution</i>	Tier 2	QL (90 ML per 1 fill)
<i>insulin degludec</i>	Tier 3	PA; QL (90 ML per 1 fill)
<i>insulin glargine u-300 conc</i>	Tier 3	PA; QL (90 ML per 1 fill)
<i>insulin glargine-yfgn</i>	Tier 3	PA; QL (90 ML per 1 claim)
<i>insulin lispro protamin-lispro</i>	Tier 3	PA; QL (90 ML per 1 fill)
<i>insulin lispro subcutaneous insulin pen</i>	Tier 2	QL (90 ML per 1 fill)
<i>insulin lispro subcutaneous insulin pen, half-unit</i>	Tier 2	QL (90 ML per 1 fill)
<i>insulin lispro subcutaneous solution</i>	Tier 2	QL (90 ML per 1 fill)
LANTUS SOLOSTAR U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)
LANTUS U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)
LEVEMIR FLEXPEN	Tier 2	QL (90 ML per 1 fill)
LEVEMIR U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)
LYUMJEV KWIKPEN U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
LYUMJEV KWIKPEN U-200 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
LYUMJEV TEMPO PEN(U-100)INSULN	Tier 3	PA; QL (90 ML per 1 fill)
LYUMJEV U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
NOVOLIN 70/30 U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
NOVOLIN 70-30 FLEXPEN U-100	Tier 3	PA; QL (90 ML per 1 fill)
NOVOLIN N FLEXPEN	Tier 2	QL (90 ML per 1 fill)
NOVOLIN N NPH U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)
NOVOLIN R FLEXPEN	Tier 2	QL (90 ML per 1 fill)
NOVOLIN R REGULAR U100 INSULIN	Tier 2	QL (90 ML per 1 fill)
NOVOLOG FLEXPEN U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
NOVOLOG MIX 70-30 U-100 INSULN	Tier 3	PA; QL (90 ML per 1 fill)
NOVOLOG MIX 70-30FLEXPEN U-100	Tier 2	QL (90 ML per 1 fill)
NOVOLOG PENFILL U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)
NOVOLOG U-100 INSULIN ASPART	Tier 3	PA; QL (90 ML per 1 fill)
REZVOGLAR KWIKPEN	Tier 3	PA; QL (90 ML per 1 Fill)

Tier 1= MCO Covered (This Drug Is Covered)

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

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

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

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

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

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

Drug Name	Tier	Restrictions/Limits
SEMGLEE(INSULIN GLARGINE-YFGN)	Tier 3	PA; QL (90 ML per 1 claim)
SEMGLEE(INSULIN GLARG-YFGN)PEN	Tier 3	PA; QL (90 ML per 1 claim)
SOLIQUA 100/33	Tier 3	PA; QL (15 ML per 28 days)
TOUJEO MAX U-300 SOLOSTAR	Tier 3	PA; QL (90 ML per 1 fill)
TOUJEO SOLOSTAR U-300 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
TRESIBA FLEXTOUCH U-100	Tier 3	PA; QL (90 ML per 1 fill)
TRESIBA FLEXTOUCH U-200	Tier 3	PA; QL (90 ML per 1 fill)
TRESIBA U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
XULTOPHY 100/3.6	Tier 3	PA; QL (15 ML per 30 days)
<b>INTERMEDIATE-ACTING INSULINS</b>		
HUMALOG MIX 50-50 INSULN U-100	Tier 2	QL (90 ML per 1 fill)
HUMALOG MIX 50-50 KWIKPEN	Tier 2	QL (90 ML per 1 fill)
HUMALOG MIX 75-25 KWIKPEN	Tier 2	QL (90 ML per 1 fill)
HUMALOG MIX 75-25(U-100)INSULN	Tier 2	QL (90 ML per 1 fill)
HUMULIN 70/30 U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)
HUMULIN 70/30 U-100 KWIKPEN	Tier 2	QL (90 ML per 1 fill)
HUMULIN N NPH INSULIN KWIKPEN	Tier 3	PA; QL (90 ML per 1 fill)
HUMULIN N NPH U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)
<i>insulin asp prt-insulin aspart</i>	Tier 2	QL (90 ML per 1 fill)
<i>insulin lispro protamin-lispro</i>	Tier 3	PA; QL (90 ML per 1 fill)
NOVOLIN 70/30 U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
NOVOLIN 70-30 FLEXPEN U-100	Tier 3	PA; QL (90 ML per 1 fill)
NOVOLIN N FLEXPEN	Tier 2	QL (90 ML per 1 fill)
NOVOLIN N NPH U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)
NOVOLOG MIX 70-30 U-100 INSULN	Tier 3	PA; QL (90 ML per 1 fill)
NOVOLOG MIX 70-30FLEXPEN U-100	Tier 2	QL (90 ML per 1 fill)
<b>LONG-ACTING INSULINS</b>		
BASAGLAR KWIKPEN U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
BASAGLAR TEMPO PEN(U-100)INSLN	Tier 3	PA; QL (90 ML per 1 fill)
<i>insulin degludec</i>	Tier 3	PA; QL (90 ML per 1 fill)
<i>insulin glargine u-300 conc</i>	Tier 3	PA; QL (90 ML per 1 fill)

Tier 1= MCO Covered (This Drug Is Covered)

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

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

PA =Prior Authorization - You (or your physician) must get approval before we willcover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that iscovered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs firstbefore other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain agerequirement.

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>insulin glargine-yfgn</i>	Tier 3	PA; QL (90 ML per 1 claim)
LANTUS SOLOSTAR U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)
LANTUS U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)
LEVEMIR FLEXPEN	Tier 2	QL (90 ML per 1 fill)
LEVEMIR U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)
REZVOGLAR KWIKPEN	Tier 3	PA; QL (90 ML per 1 Fill)
SEMGLEE(INSULIN GLARGINE-YFGN)	Tier 3	PA; QL (90 ML per 1 claim)
SEMGLEE(INSULIN GLARG-YFGN)PEN	Tier 3	PA; QL (90 ML per 1 claim)
SOLIQUA 100/33	Tier 3	PA; QL (15 ML per 28 days)
TOUJEO MAX U-300 SOLOSTAR	Tier 3	PA; QL (90 ML per 1 fill)
TOUJEO SOLOSTAR U-300 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
TRESIBA FLEXTOUCH U-100	Tier 3	PA; QL (90 ML per 1 fill)
TRESIBA FLEXTOUCH U-200	Tier 3	PA; QL (90 ML per 1 fill)
TRESIBA U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
XULTOPHY 100/3.6	Tier 3	PA; QL (15 ML per 30 days)
<b>MEGLITINIDES</b>		
<i>nateglinide</i>	Tier 2	
<i>repaglinide</i>	Tier 2	
<b>PARATHYROID AGENTS</b>		
FORTEO	Tier 3	PA
<i>teriparatide</i>	Tier 3	PA
TYMLOS	Tier 3	PA
<b>PITUITARY</b>		
<i>desmopressin nasal spray with pump</i>	Tier 1	PA
<i>desmopressin nasal spray,non-aerosol 10 mcg/spray (0.1 ml)</i>	Tier 1	PA
<i>desmopressin oral</i>	Tier 1	QL (6 tablets per 1 day)
GENOTROPIN	Tier 2	PA
GENOTROPIN MINIQUICK	Tier 2	PA
HUMATROPE INJECTION CARTRIDGE	Tier 3	PA
NGENLA	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we willcover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that iscovered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs firstbefore other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain agerequirement.

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
NORDITROPIN FLEXPRO	Tier 2	PA
NUTROPIN AQ NUSPIN	Tier 3	PA
OMNITROPE	Tier 3	PA
SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG	Tier 3	PA
SKYTROFA	Tier 3	PA
SOGROYA	Tier 3	PA
ZOMACTON	Tier 3	PA
<b>PROGESTINS</b>		
CRINONE	Tier 3	PA
<i>estradiol-norethindrone acet</i>	Tier 1	AGE (Max 64 Years)
<i>hydroxyprogesterone caproate</i>	Tier 2	
<i>medroxyprogesterone intramuscular suspension</i>	Tier 1	QL (1 ML per 75 days)
<i>medroxyprogesterone oral</i>	Tier 2	
<i>megestrol oral suspension 400 mg/10 ml (10 ml), 400 mg/10 ml (40 mg/ml), 800 mg/20 ml (20 ml)</i>	Tier 2	
<i>megestrol oral suspension 625 mg/5 ml (125 mg/ml)</i>	Tier 3	PA
<i>megestrol oral tablet</i>	Tier 1	
MYFEMBREE	Tier 2	PA; QL (28 EA per 28 days); AGE (Min 18 Years)
<i>norethindrone acetate</i>	Tier 2	
<i>norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg</i>	Tier 1	QL (1 tablet per 1 day); AGE (Max 64 Years)
<i>norethindrone ac-eth estradiol oral tablet 1-5 mg-mcg</i>	Tier 1	AGE (Max 64 Years)
ORIAHNN	Tier 2	PA; QL (56 EA per 28 days); AGE (Min 18 Years)
<i>progesterone</i>	Tier 3	PA
<i>progesterone micronized</i>	Tier 2	
PROMETRIUM	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.



Drug Name	Tier	Restrictions/Limits
PROVERA	Tier 3	PA
<b>RAPID-ACTING INSULINS</b>		
ADMELOG SOLOSTAR U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
ADMELOG U-100 INSULIN LISPRO	Tier 3	PA; QL (90 ML per 1 fill)
AFREZZA	Tier 3	PA; QL (180 cartridges per 1 fill)
APIDRA SOLOSTAR U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)
APIDRA U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)
FIASP FLEXTOUCH U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
FIASP PENFILL U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
FIASP PUMPCART	Tier 3	PA; QL (90 ML per 1 Fill)
FIASP U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
HUMALOG JUNIOR KWIKPEN U-100	Tier 2	QL (90 ML per 1 fill)
HUMALOG KWIKPEN INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML	Tier 2	QL (90 ML per 1 fill)
HUMALOG KWIKPEN INSULIN SUBCUTANEOUS INSULIN PEN 200 UNIT/ML (3 ML)	Tier 3	PA; QL (90 ML per 1 fill)
HUMALOG MIX 50-50 INSULN U-100	Tier 2	QL (90 ML per 1 fill)
HUMALOG MIX 50-50 KWIKPEN	Tier 2	QL (90 ML per 1 fill)
HUMALOG MIX 75-25 KWIKPEN	Tier 2	QL (90 ML per 1 fill)
HUMALOG MIX 75-25(U-100)INSULN	Tier 2	QL (90 ML per 1 fill)
HUMALOG TEMPO PEN(U-100)INSULN	Tier 2	QL (90 ML per 1 fill)
HUMALOG U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)
<i>insulin asp prt-insulin aspart</i>	Tier 2	QL (90 ML per 1 fill)
<i>insulin aspart u-100 subcutaneous cartridge</i>	Tier 3	PA; QL (90 ML per 1 fill)
<i>insulin aspart u-100 subcutaneous insulin pen</i>	Tier 2	QL (90 ML per 1 fill)
<i>insulin aspart u-100 subcutaneous solution</i>	Tier 2	QL (90 ML per 1 fill)
<i>insulin lispro protamin-lispro</i>	Tier 3	PA; QL (90 ML per 1 fill)
<i>insulin lispro subcutaneous insulin pen</i>	Tier 2	QL (90 ML per 1 fill)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.



Drug Name	Tier	Restrictions/Limits
<i>insulin lispro subcutaneous insulin pen, half-unit</i>	Tier 2	QL (90 ML per 1 fill)
<i>insulin lispro subcutaneous solution</i>	Tier 2	QL (90 ML per 1 fill)
LYUMJEV KWIKPEN U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
LYUMJEV KWIKPEN U-200 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
LYUMJEV TEMPO PEN(U-100)INSULN	Tier 3	PA; QL (90 ML per 1 fill)
LYUMJEV U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
NOVOLOG FLEXPEN U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
NOVOLOG MIX 70-30 U-100 INSULN	Tier 3	PA; QL (90 ML per 1 fill)
NOVOLOG MIX 70-30FLEXPEN U-100	Tier 2	QL (90 ML per 1 fill)
NOVOLOG PENFILL U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)
NOVOLOG U-100 INSULIN ASPART	Tier 3	PA; QL (90 ML per 1 fill)
<b>SHORT-ACTING INSULINS</b>		
HUMULIN 70/30 U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)
HUMULIN 70/30 U-100 KWIKPEN	Tier 2	QL (90 ML per 1 fill)
HUMULIN R REGULAR U-100 INSULN	Tier 2	QL (90 ML per 1 fill)
HUMULIN R U-500 (CONC) INSULIN	Tier 2	QL (90 ML per 1 fill)
HUMULIN R U-500 (CONC) KWIKPEN	Tier 2	QL (90 ML per 1 fill)
NOVOLIN 70/30 U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
NOVOLIN 70-30 FLEXPEN U-100	Tier 3	PA; QL (90 ML per 1 fill)
NOVOLIN R FLEXPEN	Tier 2	QL (90 ML per 1 fill)
NOVOLIN R REGULAR U100 INSULIN	Tier 2	QL (90 ML per 1 fill)
<b>SODIUM-GLUC COTRANSPORT 2 (SGLT2) INHIB</b>		
<i>dapaglifloz propaned-metformin</i>	Tier 3	PA
<i>dapagliflozin propanediol</i>	Tier 3	PA
FARXIGA	Tier 2	
GLYXAMBI	Tier 2	PA
INPEFA ORAL TABLET 200 MG	Tier 3	PA
INVOKAMET	Tier 2	
INVOKAMET XR	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we willcover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that iscovered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs firstbefore other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain agerequirement.

Drug Name	Tier	Restrictions/Limits
INVOKANA	Tier 2	
JARDIANCE	Tier 2	
QTERN	Tier 3	PA
SEGLUROMET	Tier 3	PA
STEGLATRO	Tier 3	PA
STEGLUJAN	Tier 3	PA
SYNJARDY	Tier 2	
SYNJARDY XR	Tier 3	PA
TRIJARDY XR	Tier 3	PA
XIGDUO XR	Tier 2	
<b>SOMATOSTATIN AGONISTS</b>		
<i>octreotide acetate injection solution 1,000 mcg/ml, 200 mcg/ml</i>	Tier 1	PA
<b>SOMATOTROPIN AGONISTS</b>		
INCRELEX	Tier 1	PA
<b>SULFONYLUREAS</b>		
DUETACT	Tier 3	PA
<i>glimepiride</i>	Tier 2	
<i>glipizide oral tablet 10 mg, 5 mg</i>	Tier 2	
<i>glipizide oral tablet extended release 24hr</i>	Tier 2	
<i>glipizide-metformin</i>	Tier 3	PA
GLUCOTROL XL	Tier 3	PA
<i>glyburide</i>	Tier 2	
<i>glyburide micronized</i>	Tier 2	
<i>glyburide-metformin</i>	Tier 2	
<i>pioglitazone-glimepiride</i>	Tier 3	PA
<b>THIAZOLIDINEDIONES</b>		
ACTOPLUS MET ORAL TABLET 15-850 MG	Tier 3	PA
ACTOS	Tier 3	PA
<i>alogliptin-pioglitazone oral tablet 12.5-30 mg, 25-15 mg, 25-30 mg, 25-45 mg</i>	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
DUETACT	Tier 3	PA
OSENI ORAL TABLET 12.5-30 MG, 25-15 MG, 25-30 MG, 25-45 MG	Tier 3	PA
<i>pioglitazone</i>	Tier 2	
<i>pioglitazone-glimepiride</i>	Tier 3	PA
<i>pioglitazone-metformin</i>	Tier 3	PA
<b>THYROID AGENTS</b>		
ADTHYZA ORAL TABLET 130 MG, 16.25 MG, 32.5 MG, 65 MG, 97.5 MG	Tier 1	
ARMOUR THYROID	Tier 1	
CYTOMEL	Tier 1	
ERMEZA	Tier 1	
<i>levothyroxine intravenous recon soln</i>	Tier 1	
<i>levothyroxine oral tablet</i>	Tier 1	
LEVOXYL ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 50 MCG, 75 MCG, 88 MCG	Tier 1	
<i>liothyronine</i>	Tier 1	
NP THYROID	Tier 1	
SYNTHROID	Tier 1	
THYQUIDITY	Tier 1	
TIROSINT ORAL CAPSULE 100 MCG, 112 MCG, 125 MCG, 13 MCG, 137 MCG, 150 MCG, 25 MCG, 50 MCG, 75 MCG, 88 MCG	Tier 1	
TIROSINT-SOL ORAL SOLUTION 100 MCG/ML, 112 MCG/ML, 125 MCG/ML, 13 MCG/ML, 137 MCG/ML, 150 MCG/ML, 175 MCG/ML, 200 MCG/ML, 25 MCG/ML, 50 MCG/ML, 75 MCG/ML, 88 MCG/ML	Tier 1	
UNITHROID	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug Name	Tier	Restrictions/Limits
<b>IMMUNOMODULATORY AGENT (90:00)</b>		
<b>AMINO ACID POLYMERS</b>		
COPAXONE SUBCUTANEOUS SYRINGE 20 MG/ML	Tier 2	
COPAXONE SUBCUTANEOUS SYRINGE 40 MG/ML	Tier 3	PA
<i>glatiramer</i>	Tier 3	PA
GLATOPA	Tier 3	PA
<b>ANTIMETABOLITES</b>		
AUBAGIO	Tier 3	PA
MAVENCLAD (10 TABLET PACK)	Tier 3	PA
MAVENCLAD (4 TABLET PACK)	Tier 3	PA
MAVENCLAD (5 TABLET PACK)	Tier 3	PA
MAVENCLAD (6 TABLET PACK)	Tier 3	PA
MAVENCLAD (7 TABLET PACK)	Tier 3	PA
MAVENCLAD (8 TABLET PACK)	Tier 3	PA
MAVENCLAD (9 TABLET PACK)	Tier 3	PA
<i>teriflunomide</i>	Tier 3	PA
<b>ANTIMETABOLITES, IMMUNOSUPP THERAPY MISC</b>		
<i>azathioprine</i>	Tier 1	
<i>mycophenolate mofetil</i>	Tier 1	
<i>mycophenolate mofetil (hcl)</i>	Tier 1	
<i>mycophenolate sodium</i>	Tier 1	
<b>CALCINEURIN INHIBITORS, MISC (90:28)</b>		
CEQUA	Tier 3	PA; QL (60 ampules per 30 days)
<i>cyclosporine modified</i>	Tier 1	
<i>cyclosporine ophthalmic (eye)</i>	Tier 3	PA; QL (60 ampules per 30 days)
<i>cyclosporine oral capsule</i>	Tier 1	
RESTASIS	Tier 2	QL (60 ampules per 30 days)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug Name	Tier	Restrictions/Limits
RESTASIS MULTIDOSE	Tier 2	QL (5.5 ML per 30 days)
<i>tacrolimus oral</i>	Tier 1	
<b>DISEASE-MODIFYING ANTIRHEUMAT DRUGS MISC</b>		
ENTYVIO	Tier 3	PA
ENTYVIO PEN	Tier 3	PA
ORENCIA	Tier 3	PA
ORENCIA CLICKJECT	Tier 3	PA
<b>DISEASE-MODIFYING ANTIRHEUMATIC DRUGS</b>		
AZULFIDINE	Tier 3	PA
AZULFIDINE EN-TABS	Tier 3	PA
JYLAMVO	Tier 1	
<i>methotrexate sodium</i>	Tier 1	
<i>methotrexate sodium (pf) injection solution</i>	Tier 1	
RIABNI	Tier 1	
<i>sulfasalazine</i>	Tier 2	
TREMFYA	Tier 3	PA
XATMEP	Tier 1	
<b>FUMARATES</b>		
BAFIERTAM	Tier 3	PA; QL (120 capsules per 30 days)
<i>dimethyl fumarate</i>	Tier 2	
TECFIDERA	Tier 3	PA
VUMERITY	Tier 3	PA
<b>IMMUNOMODULATORY AGENT (90:00)</b>		
<i>cyclophosphamide oral capsule</i>	Tier 1	
<i>mercaptopurine</i>	Tier 1	
<b>INTERFERONS</b>		
AVONEX INTRAMUSCULAR PEN INJECTOR KIT	Tier 2	QL (4 EA per 1 Fill)
AVONEX INTRAMUSCULAR SYRINGE KIT	Tier 2	QL (4 syringes per 1 fill)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
BETASERON	Tier 2	
PLEGRIDY	Tier 3	PA
REBIF (WITH ALBUMIN) SUBCUTANEOUS SYRINGE 22 MCG/0.5 ML	Tier 3	PA
REBIF (WITH ALBUMIN) SUBCUTANEOUS SYRINGE 44 MCG/0.5 ML	Tier 3	PA; QL (0.25 ML per 1 day)
REBIF REBIDOSE	Tier 3	PA
REBIF TITRATION PACK	Tier 3	PA
<b>INTERLEUKIN INHIBITOR AGENTS, MISC</b>		
XOLAIR SUBCUTANEOUS AUTO-INJECTOR 150 MG/ML, 300 MG/2 ML	Tier 2	PA; AGE (Min 6 Years)
XOLAIR SUBCUTANEOUS RECON SOLN	Tier 3	PA
XOLAIR SUBCUTANEOUS SYRINGE 150 MG/ML, 75 MG/0.5 ML	Tier 2	PA; AGE (Min 6 Years)
<b>INTERLEUKIN-MEDIATED AGENTS, MISC</b>		
ACTEMRA ACTPEN	Tier 3	PA
ACTEMRA SUBCUTANEOUS	Tier 3	PA
COSENTYX (2 SYRINGES)	Tier 2	
COSENTYX PEN	Tier 2	
COSENTYX PEN (2 PENS)	Tier 2	
COSENTYX SUBCUTANEOUS	Tier 2	
COSENTYX UNOREADY PEN	Tier 2	
KEVZARA	Tier 3	PA
STELARA	Tier 3	PA
TALTZ AUTOINJECTOR	Tier 3	PA
TALTZ AUTOINJECTOR (2 PACK)	Tier 3	PA
TALTZ AUTOINJECTOR (3 PACK)	Tier 3	PA
TALTZ SYRINGE	Tier 3	PA
<b>JANUS KINASE INHIBITORS, MISCELLANEOUS</b>		
CIBINQO	Tier 3	PA; AGE (Min 12 Years)
OLUMIANT	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
RINVOQ	Tier 3	PA
XELJANZ	Tier 3	PA
XELJANZ XR	Tier 3	PA
<b>MONOCARBOXYLIC ACID AMIDE AGENTS</b>		
<i>leflunomide</i>	Tier 1	QL (1 tablet per 1 day)
<b>MONOCLONAL ANTIBODIE(S)</b>		
ENSPRYNG	Tier 1	PA; QL (1 ML per 4 weeks); AGE (Min 18 Years)
<b>MONOCLONAL ANTIBODIES</b>		
KESIMPTA PEN	Tier 3	PA
<b>MTOR INHIBITORS, MISCELLANEOUS</b>		
<i>sirolimus oral tablet</i>	Tier 1	
<b>PHOSPHODIESTERASE-4 INHIBITORS, MISC</b>		
OTEZLA	Tier 3	PA
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)	Tier 3	PA
<b>SPHINGOSINE 1-PHOSPHATE (S1P) AGENTS</b>		
<i>fingolimod</i>	Tier 3	PA
GILENYA	Tier 2	
MAYZENT	Tier 3	PA
MAYZENT STARTER(FOR 1MG MAINT)	Tier 3	PA
MAYZENT STARTER(FOR 2MG MAINT)	Tier 3	PA
PONVORY	Tier 3	PA; AGE (Min 18 Years and Max 55 Years)
PONVORY 14-DAY STARTER PACK	Tier 3	PA; AGE (Min 18 Years and Max 55 Years)
TASCENSO ODT	Tier 3	PA; AGE (Min 10 Years and Max 17 Years)
ZEPOSIA	Tier 3	PA
ZEPOSIA STARTER KIT (28-DAY)	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.



Drug Name	Tier	Restrictions/Limits
ZEPOSIA STARTER PACK (7-DAY)	Tier 3	PA
<b>TUMOR NECROSIS FACTOR INHIBITORS, MISC</b>		
ABRILADA(CF)	Tier 3	PA
ABRILADA(CF) PEN	Tier 3	PA
<i>adalimumab-adaz</i>	Tier 3	PA
<i>adalimumab-adbm subcutaneous pen injector kit</i>	Tier 3	PA
<i>adalimumab-adbm subcutaneous syringe kit 20 mg/0.4 ml, 40 mg/0.4 ml, 40 mg/0.8 ml</i>	Tier 3	PA
ADALIMUMAB-ADBM(CF) PEN CROHNS	Tier 3	PA
ADALIMUMAB-ADBM(CF) PEN PS-UV	Tier 3	PA
<i>adalimumab-fkjp subcutaneous pen injector kit</i>	Tier 3	PA
<i>adalimumab-fkjp subcutaneous syringe kit</i>	Tier 3	PA
AMJEVITA(CF)	Tier 3	PA
AMJEVITA(CF) AUTOINJECTOR	Tier 3	PA
CIMZIA	Tier 3	PA
CIMZIA POWDER FOR RECONST	Tier 3	PA
CIMZIA STARTER KIT	Tier 3	PA
CYLTEZO(CF)	Tier 3	PA
CYLTEZO(CF) PEN	Tier 3	PA
CYLTEZO(CF) PEN CROHN'S-UC-HS	Tier 3	PA
CYLTEZO(CF) PEN PSORIASIS-UV	Tier 3	PA
ENBREL MINI	Tier 2	
ENBREL SUBCUTANEOUS SOLUTION	Tier 2	
ENBREL SUBCUTANEOUS SYRINGE	Tier 2	
ENBREL SURECLICK	Tier 2	
HADLIMA	Tier 3	PA
HADLIMA PUSHTOUCH	Tier 3	PA
HADLIMA(CF)	Tier 3	PA
HADLIMA(CF) PUSHTOUCH	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug Name	Tier	Restrictions/Limits
HULIO(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT	Tier 3	PA
HULIO(CF) SUBCUTANEOUS SYRINGE KIT	Tier 3	PA
HUMIRA PEN	Tier 2	
HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	Tier 2	
HUMIRA(CF)	Tier 2	
HUMIRA(CF) PEDI CROHNS STARTER	Tier 2	
HUMIRA(CF) PEN	Tier 2	
HUMIRA(CF) PEN CROHNS-UC-HS	Tier 2	
HUMIRA(CF) PEN PSOR-UV-ADOL HS	Tier 2	
HYRIMOZ PEN CROHN'S-UC STARTER	Tier 3	PA
HYRIMOZ PEN PSORIASIS STARTER	Tier 3	PA
HYRIMOZ(CF)	Tier 3	PA
HYRIMOZ(CF) PEDI CROHN STARTER	Tier 3	PA
HYRIMOZ(CF) PEN	Tier 3	PA
IDACIO(CF)	Tier 3	PA
IDACIO(CF) PEN	Tier 3	PA
IDACIO(CF) PEN CROHN-UC STARTR	Tier 3	PA
IDACIO(CF) PEN PSORIASIS START	Tier 3	PA
SIMPONI	Tier 3	PA
SIMPONI ARIA	Tier 3	PA
YUFLYMA(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR, KIT 40 MG/0.4 ML	Tier 3	PA
YUFLYMA(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML	Tier 3	PA
YUSIMRY(CF) PEN	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug Name	Tier	Restrictions/Limits
<b>MISCELLANEOUS THERAPEUTIC AGENTS</b>		
<b>5-ALPHA-REDUCTASE INHIBITORS</b>		
AVODART	Tier 3	PA
<i>dutasteride</i>	Tier 2	
<i>dutasteride-tamsulosin</i>	Tier 3	PA
ENTADFI	Tier 1	PA
<i>finasteride oral tablet 5 mg</i>	Tier 2	
PROSCAR	Tier 3	PA
<b>ANTIDOTES</b>		
KLOXXADO	Tier 1	QL (2 devices per 90 days)
<i>magnesium sulfate in d5w intravenous piggyback 1 gram/100 ml</i>	Tier 1	
<i>magnesium sulfate in water</i>	Tier 1	
<i>magnesium sulfate injection</i>	Tier 1	
<i>naloxone injection solution</i>	Tier 1	QL (2 doses per 30 days)
<i>naloxone injection syringe</i>	Tier 1	QL (2 doses per 30 days)
<i>naloxone nasal</i>	Tier 2	QL (6 doses per 90 days)
NARCAN	Tier 2	QL (6 doses per 90 days)
RENVELA	Tier 3	PA
<i>sevelamer carbonate oral powder in packet</i>	Tier 3	PA
<i>sevelamer carbonate oral tablet</i>	Tier 2	PA
<i>sevelamer hcl</i>	Tier 3	PA
<i>sodium polystyrene sulfonate oral powder</i>	Tier 1	
ZIMHI	Tier 1	QL (3 syringes per 90 days)
<b>ANTIGOUT AGENTS</b>		
<i>allopurinol</i>	Tier 2	
<i>colchicine oral capsule</i>	Tier 3	PA
<i>colchicine oral tablet</i>	Tier 2	
COLCRYS	Tier 3	PA
<i>febuxostat</i>	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug Name	Tier	Restrictions/Limits
GLOPERBA	Tier 3	PA
INDOCIN ORAL	Tier 3	PA
<i>indomethacin oral capsule</i>	Tier 2	
<i>indomethacin oral capsule, extended release</i>	Tier 3	PA
<i>indomethacin oral suspension</i>	Tier 3	PA
MITIGARE	Tier 3	PA
<i>probenecid</i>	Tier 2	
<i>probenecid-colchicine</i>	Tier 2	
ULORIC	Tier 3	PA
ZYLOPRIM ORAL TABLET 100 MG	Tier 3	PA
<b>BONE ANABOLIC AGENTS</b>		
FORTEO	Tier 3	PA
<i>teriparatide</i>	Tier 3	PA
TYMLOS	Tier 3	PA
<b>BONE RESORPTION INHIBITORS</b>		
ACTONEL ORAL TABLET 150 MG	Tier 3	PA; QL (4 EA per 28 days)
ACTONEL ORAL TABLET 35 MG	Tier 3	PA; QL (4 tablets per 28 dayss)
<i>alendronate oral solution</i>	Tier 3	PA
<i>alendronate oral tablet 10 mg, 5 mg</i>	Tier 2	
<i>alendronate oral tablet 35 mg</i>	Tier 2	QL (4 tablets per 28 days)
<i>alendronate oral tablet 70 mg</i>	Tier 2	QL (4 tablets per 30 dayss)
ATELVIA	Tier 3	PA; QL (4 tablets per 30 dayss)
<i>calcitonin (salmon) nasal</i>	Tier 2	
EVISTA	Tier 3	PA
FOSAMAX ORAL TABLET 70 MG	Tier 3	PA; QL (4 tablets per 28 dayss)
FOSAMAX PLUS D	Tier 3	PA; QL (4 tablets per 28 dayss)
<i>ibandronate oral</i>	Tier 3	PA; QL (1 tablet per 28 dayss)
<i>raloxifene</i>	Tier 2	
<i>risedronate oral tablet 150 mg, 30 mg, 5 mg</i>	Tier 3	PA
<i>risedronate oral tablet 35 mg</i>	Tier 3	PA; QL (4 tablets per 28 dayss)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we willcover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that iscovered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs firstbefore other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain agerequirement.

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>risedronate oral tablet, delayed release (dr/ec)</i>	Tier 3	PA; QL (4 tablets per 30 days)
<b>CARIOSTATIC AGENTS</b>		
MULTI-VIT WITH FLUORIDE-IRON	Tier 1	QL (2 ML per 1 day); AGE (Max 12 Years)
MULTI-VITAMIN WITH FLUORIDE ORAL DROPS	Tier 1	QL (2 ML per 1 day); AGE (Max 12 Years)
MULTI-VITAMIN WITH FLUORIDE ORAL TABLET,CHEWABLE 0.25 MG	Tier 1	QL (1 tablet per 1 day)
MULTI-VITAMIN WITH FLUORIDE ORAL TABLET,CHEWABLE 0.5 MG, 1 MG	Tier 1	QL (1 tablet per 1 day); AGE (Max 12 Years)
MVC-FLUORIDE	Tier 1	QL (1 tablet per 1 day); AGE (Max 12 Years)
TRI-VITAMIN WITH FLUORIDE	Tier 1	QL (2 drops per 1 day); AGE (Max 12 Years)
VITAMINS A,C,D AND FLUORIDE ORAL DROPS 0.25 MG FLUOR. (0.55 MG)/ML	Tier 1	QL (2 ML per 1 day); AGE (Max 12 Years)
<b>DISEASE-MODIFYING ANTIRHEUMATIC AGENTS</b>		
<i>hydroxychloroquine</i>	Tier 1	
<b>IMMUNOMODULATORY AGENTS</b>		
<i>hydroxychloroquine</i>	Tier 1	
<i>leflunomide</i>	Tier 1	QL (1 tablet per 1 day)
<i>lenalidomide oral capsule 10 mg, 15 mg, 25 mg, 5 mg</i>	Tier 1	
ORENCIA	Tier 3	PA
ORENCIA CLICKJECT	Tier 3	PA
OTEZLA	Tier 3	PA
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)	Tier 3	PA
POMALYST	Tier 1	
THALOMID ORAL CAPSULE 100 MG, 50 MG	Tier 1	PA
VELSIPITY	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug Name	Tier	Restrictions/Limits
<b>IMMUNOSUPPRESSIVE AGENTS</b>		
<i>everolimus (immunosuppressive) oral tablet 1 mg</i>	Tier 1	
<b>OTHER MISCELLANEOUS THERAPEUTIC AGENTS</b>		
<i>acetylcysteine</i>	Tier 1	
AMPYRA	Tier 3	PA
<i>dalfampridine</i>	Tier 1	PA; QL (2 tablets per 1 day); AGE (Min 18 Years and Max 70 Years)
REZUROCK	Tier 1	
<b>PROTECTIVE AGENTS</b>		
<i>adapalene topical gel 0.1 %</i>	Tier 1	QL (45 GM per 30 days)
<i>adapalene topical gel 0.3 %</i>	Tier 1	QL (1.5 GM per 1 day); AGE (Max 30 Years)
DIFFERIN TOPICAL GEL 0.1 %	Tier 1	QL (45 GM per 30 days)
<b>NONHORMONAL CONTRACEPTIVES</b>		
<b>NONHORMONAL CONTRACEPTIVES</b>		
AIMSCO LATEX CONDOM	Tier 1	QL (36 condoms per 30 days)
CAYA CONTOURED	Tier 1	
FANTASY CONDOM	Tier 1	QL (36 condoms per 30 days)
FC2 FEMALE CONDOM	Tier 1	QL (36 condoms per 30 days)
FEMCAP	Tier 1	
KIMONO CONDOMS(NON-LUBRICATED)	Tier 1	QL (36 condoms per 30 days)
KIMONO MICROTHIN AQUA LUBE CON	Tier 1	QL (36 condoms per 30 days)
KIMONO MICROTHIN CONDOMS	Tier 1	QL (36 condoms per 30 days)
KIMONO MICROTHIN LARGE CONDOMS	Tier 1	QL (36 condoms per 30 days)
KIMONO TEXTURED CONDOMS	Tier 1	QL (36 condoms per 30 days)
PHEXXI	Tier 1	QL (180 GM per 30 days)
TRUSTEX LATEX CONDOM	Tier 1	QL (36 condoms per 30 days)
TRUSTEX LUBRICATED CONDOMS	Tier 1	QL (36 condoms per 30 days)
TRUSTEX NON-LUB CONDOMS	Tier 1	QL (36 condoms per 30 days)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug Name	Tier	Restrictions/Limits
TRUSTEX-RIA LUB/SPERMICIDE	Tier 1	QL (36 condoms per 30 days)
TRUSTEX-RIA NON-LUB CONDOMS	Tier 1	QL (36 condoms per 30 days)
WIDE-SEAL DIAPHRAGM 60	Tier 1	
WIDE-SEAL DIAPHRAGM 65	Tier 1	
WIDE-SEAL DIAPHRAGM 70	Tier 1	
WIDE-SEAL DIAPHRAGM 75	Tier 1	
WIDE-SEAL DIAPHRAGM 80	Tier 1	
WIDE-SEAL DIAPHRAGM 85	Tier 1	
WIDE-SEAL DIAPHRAGM 90	Tier 1	
WIDE-SEAL DIAPHRAGM 95	Tier 1	
<b>OXYTOCICS</b>		
<b>OXYTOCICS</b>		
<i>methylergonovine oral</i>	Tier 1	QL (28 tablets per 180 days); AGE (Min 12 Years)
<b>RESPIRATORY TRACT AGENTS</b>		
<b>ALPHA AND BETA ADRENERGIC AGONIST(RESPR)</b>		
AUVI-Q	Tier 3	PA; QL (4 injectors per 1 Fill)
<i>epinephrine injection auto-injector</i>	Tier 2	QL (4 injectors per 1 fill)
EPIPEN	Tier 2	QL (4 injectors per 1 fill)
EPIPEN 2-PAK	Tier 2	QL (4 injectors per 1 fill)
EPIPEN JR	Tier 2	QL (4 injectors per 1 fill)
EPIPEN JR 2-PAK	Tier 2	QL (4 injectors per 1 fill)
SYMJEPI	Tier 3	PA
<b>ANTICHOLINERGIC AGENTS (RESPIR. TRACT)</b>		
ANORO ELLIPTA	Tier 2	QL (3 inhalers per 90 days)
ATROVENT HFA	Tier 2	QL (2 inhalers per 30 days)
BEVESPI AEROSPHERE	Tier 2	QL (3 inhalers per 90 days)
BREZTRI AEROSPHERE	Tier 3	PA; QL (3 inhalers per 90 days)
COMBIVENT RESPIMAT	Tier 2	QL (5 inhalers per 90 days)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.



<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
DUAKLIR PRESSAIR	Tier 3	PA
INCRUSE ELLIPTA	Tier 2	QL (3 inhalers per 90 days)
<i>ipratropium bromide inhalation</i>	Tier 2	
<i>ipratropium-albuterol</i>	Tier 2	
SPIRIVA RESPIMAT	Tier 2	QL (1 inhaler per 30 days)
SPIRIVA WITH HANDIHALER	Tier 2	QL (1 capsule per 1 day)
STIOLTO RESPIMAT	Tier 2	QL (3 inhalers per 90 days)
<i>tiotropium bromide</i>	Tier 3	QL (1 capsule per 1 day)
TRELEGY ELLIPTA	Tier 2	QL (3 inhalers per 90 days)
TUDORZA PRESSAIR	Tier 3	PA
<b>ANTITUSSIVES</b>		
<i>codeine sulfate</i>	Tier 2	QL (180 tablets per 30 days); AGE (Min 12 Years)
<b>FIRST GENERATION ANTIHIST.(RESPIR TRACT)</b>		
ALLER-CHLOR	Tier 1	
ALLER-G-TIME	Tier 1	AGE (Max 64 Years)
ALLERGY (CHLORPHENIRAMINE)	Tier 1	
ALLERGY RELIEF(CHLORPHENIRAMN)	Tier 1	
ALLERGY RELIEF(DIPHENHYDRAMIN) ORAL TABLET	Tier 1	AGE (Max 64 Years)
ALLERGY-TIME	Tier 1	
BANOPHEN ORAL TABLET	Tier 1	AGE (Max 64 Years)
<i>carbinoxamine maleate oral liquid</i>	Tier 1	
<i>carbinoxamine maleate oral tablet 4 mg</i>	Tier 1	
<i>chlorpheniramine maleate oral tablet</i>	Tier 1	
<i>chlorpheniramine maleate oral tablet extended release</i>	Tier 1	
CHLORTABS	Tier 1	
<i>cyproheptadine</i>	Tier 1	AGE (Max 64 Years)
DAYHIST ALLERGY	Tier 1	
<i>dimenhydrinate oral</i>	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>diphenhydramine hcl injection solution 50 mg/ml</i>	Tier 1	AGE (Max 64 Years)
<i>diphenhydramine hcl injection syringe</i>	Tier 1	AGE (Max 64 Years)
<i>diphenhydramine hcl oral capsule</i>	Tier 1	AGE (Max 64 Years)
<i>diphenhydramine hcl oral liquid</i>	Tier 1	
<i>diphenhydramine hcl oral tablet</i>	Tier 1	AGE (Max 64 Years)
PHARBECHLOR	Tier 1	
<i>promethazine oral</i>	Tier 1	AGE (Min 2 Years and Max 64 Years)
WAL-FINATE	Tier 1	
<b>INTERLEUKIN ANTAGONISTS</b>		
FASENRA PEN	Tier 2	PA; AGE (Min 12 Years)
NUCALA SUBCUTANEOUS AUTO-INJECTOR	Tier 3	PA; AGE (Min 6 Years)
NUCALA SUBCUTANEOUS SYRINGE 100 MG/ML	Tier 3	PA; AGE (Min 6 Years)
TEZSPIRE SUBCUTANEOUS PEN INJECTOR	Tier 3	PA; AGE (Min 12 Years)
<b>LEUKOTRIENE MODIFIERS</b>		
ACCOLATE	Tier 3	PA
<i>montelukast oral granules in packet</i>	Tier 3	PA; AGE (Max 5 Years)
<i>montelukast oral tablet</i>	Tier 2	
<i>montelukast oral tablet, chewable 4 mg</i>	Tier 2	AGE (Max 5 Years)
<i>montelukast oral tablet, chewable 5 mg</i>	Tier 2	AGE (Max 14 Years)
SINGULAIR ORAL GRANULES IN PACKET	Tier 3	PA; AGE (Max 5 Years)
SINGULAIR ORAL TABLET	Tier 3	PA
SINGULAIR ORAL TABLET, CHEWABLE 4 MG	Tier 3	PA; AGE (Max 5 Years)
SINGULAIR ORAL TABLET, CHEWABLE 5 MG	Tier 3	PA; AGE (Max 14 Years)
<i>zafirlukast</i>	Tier 3	PA
<i>zileuton</i>	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug Name	Tier	Restrictions/Limits
ZYFLO	Tier 3	PA
<b>MAST-CELL STABILIZERS</b>		
ALOCRIAL	Tier 3	PA
<i>cromolyn nasal</i>	Tier 1	
<i>cromolyn ophthalmic (eye)</i>	Tier 2	
NASALCROM	Tier 1	
<b>MUCOLYTIC AGENTS</b>		
<i>acetylcysteine</i>	Tier 1	
PULMOZYME	Tier 1	PA; QL (75 EA per 30 days)
<b>NASAL PREPARATIONS (STEROIDS)</b>		
24 HOUR NASAL ALLERGY	Tier 3	PA
ALLERGY RELIEF (FLUTICASONE)	Tier 3	PA
<i>azelastine-fluticasone</i>	Tier 3	PA
<i>budesonide nasal</i>	Tier 3	PA
CHILDREN'S FLONASE ALLERGY RLF	Tier 3	PA
DYMISTA	Tier 3	PA
<i>flunisolide</i>	Tier 3	PA
<i>fluticasone propionate nasal</i>	Tier 2	
<i>mometasone nasal</i>	Tier 3	PA
NASAL ALLERGY	Tier 3	PA
NASONEX 24HR ALLERGY	Tier 3	PA
OMNARIS	Tier 3	PA
QNASL	Tier 3	PA
RYALTRIS	Tier 3	PA
<i>triamcinolone acetonide nasal</i>	Tier 3	PA
XHANCE	Tier 3	PA
ZETONNA	Tier 3	PA
<b>ORALLY INHALED PREPARATIONS (STEROIDS)</b>		
ALVESCO	Tier 3	
ARMONAIR DIGIHALER	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug Name	Tier	Restrictions/Limits
ARNUIITY ELLIPTA	Tier 3	PA
ASMANEX HFA	Tier 3	PA; QL (3 inhalers per 90 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG/ ACTUATION (30)	Tier 2	QL (1 inhaler per 30 days); AGE (Max 11 Years)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 220 MCG/ ACTUATION (120), 220 MCG/ ACTUATION (14), 220 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (60)	Tier 2	QL (1 inhaler per 30 days)
BREZTRI AEROSPHERE	Tier 3	PA; QL (3 inhalers per 90 days)
<i>budesonide inhalation</i>	Tier 2	QL (2 respules per 1 day)
<i>fluticasone propionate inhalation blister with device</i>	Tier 3	PA
<i>fluticasone propionate inhalation hfa aerosol inhaler 110 mcg/actuation, 44 mcg/actuation</i>	Tier 3	PA; QL (3 inhalers per 90 days)
<i>fluticasone propionate inhalation hfa aerosol inhaler 220 mcg/actuation</i>	Tier 3	PA; QL (6 inhalers per 90 days)
PULMICORT	Tier 3	PA; QL (2 respules per 1 day)
PULMICORT FLEXHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 180 MCG/ACTUATION	Tier 3	PA; QL (6 inhalers per 90 days)
PULMICORT FLEXHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 90 MCG/ACTUATION	Tier 3	PA; QL (3 inhalers per 90 days)
QVAR REDHALER	Tier 3	PA
TRELEGY ELLIPTA	Tier 2	QL (3 inhalers per 90 days)
<b>PHOSPHODIESTERASE TYPE 4 INHIBITORS</b>		
DALIRESP	Tier 3	PA
<i>roflumilast</i>	Tier 1	PA
ZORYVE TOPICAL CREAM	Tier 1	PA; AGE (Min 6 Years)
ZORYVE TOPICAL FOAM	Tier 1	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug Name	Tier	Restrictions/Limits
<b>PHOSPHODIESTERASE-5 INHIBITORS (RESPIR)</b>		
LIQREV	Tier 3	PA
REVATIO ORAL	Tier 3	PA
<i>sildenafil (pulm.hypertension) oral</i>	Tier 2	PA
<b>PROSTACYCLIN &amp; PROSTACYCLIN DERIVATIVES</b>		
VENTAVIS	Tier 2	PA
<b>RESPIRATORY TRACT AGENTS, MISCELLANEOUS</b>		
BRONCHITOL	Tier 1	PA; QL (560 capsules per 28 days); AGE (Min 18 Years)
<b>SECOND GENERATION ANTIHIST(RESPIR TRACT)</b>		
24HR ALLERGY RELIEF	Tier 2	
ALL DAY ALLERGY (CETIRIZINE) ORAL SOLUTION	Tier 2	
ALL DAY ALLERGY (CETIRIZINE) ORAL TABLET	Tier 2	
ALLER-EASE ORAL TABLET 180 MG	Tier 2	
ALLERGY RELIEF (CETIRIZINE) ORAL CAPSULE	Tier 3	PA
ALLERGY RELIEF (CETIRIZINE) ORAL TABLET 10 MG	Tier 2	
ALLERGY RELIEF (LORATADINE) ORAL SOLUTION	Tier 2	
ALLERGY RELIEF (LORATADINE) ORAL TABLET	Tier 2	
ALLERGY RELIEF (LORATADINE) ORAL TABLET,DISINTEGRATING 10 MG	Tier 2	
<i>azelastine-fluticasone</i>	Tier 3	PA
<i>cetirizine oral solution 1 mg/ml</i>	Tier 2	
<i>cetirizine oral solution 5 mg/5 ml</i>	Tier 3	PA
<i>cetirizine oral tablet</i>	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>cetirizine oral tablet, chewable</i>	Tier 3	PA
CHILD ALLERGY RELF(CETIRIZINE)	Tier 2	
CHILDREN'S ALLERGY RELIEF(FEX)	Tier 2	
CHILDREN'S ALLERGY RELIEF(LOR) ORAL SOLUTION	Tier 2	
CHILDREN'S ALLERGY(CETIRIZINE)	Tier 2	
CHILDREN'S CETIRIZINE ORAL SOLUTION	Tier 2	
CHILDREN'S CETIRIZINE ORAL TABLET,CHEWABLE	Tier 3	PA
CHILDREN'S LORATADINE	Tier 2	
CHILD'S ALL DAY ALLERGY(CETIR)	Tier 2	
CLARINEX ORAL TABLET	Tier 3	PA
<i>desloratadine oral tablet</i>	Tier 3	PA
<i>desloratadine oral tablet, disintegrating 2.5 mg</i>	Tier 3	PA; AGE (Max 11 Years)
<i>desloratadine oral tablet, disintegrating 5 mg</i>	Tier 3	PA
DYMISTA	Tier 3	PA
<i>fexofenadine</i>	Tier 2	
<i>levocetirizine oral solution</i>	Tier 3	PA
<i>levocetirizine oral tablet</i>	Tier 2	
<i>loratadine oral solution</i>	Tier 2	
<i>loratadine oral tablet</i>	Tier 2	
<b>SELECT.BETA-2-ADRENERGIC AGONIST(RESPIR)</b>		
<i>albuterol sulfate inhalation hfa aerosol inhaler</i>	Tier 3	QL (2 inhalers per 30 days)
<i>albuterol sulfate inhalation solution for nebulization</i>	Tier 2	
ANORO ELLIPTA	Tier 2	QL (3 inhalers per 90 days)
<i>arformoterol</i>	Tier 3	PA
BEVESPI AEROSPHERE	Tier 2	QL (3 inhalers per 90 days)
BREZTRI AEROSPHERE	Tier 3	PA; QL (3 inhalers per 90 days)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
BROVANA	Tier 3	PA
COMBIVENT RESPIMAT	Tier 2	QL (5 inhalers per 90 days)
DUAKLIR PRESSAIR	Tier 3	PA
<i>formoterol fumarate</i>	Tier 3	PA
<i>ipratropium-albuterol</i>	Tier 2	
<i>levalbuterol hcl</i>	Tier 3	PA
<i>levalbuterol tartrate</i>	Tier 3	PA; QL (2 inhalers per 30 days)
PERFOROMIST	Tier 3	PA
PROAIR DIGIHALER	Tier 3	PA; QL (1 inhaler per 30 days)
PROAIR RESPICLICK	Tier 3	PA; QL (1 inhaler per 30 days)
SEREVENT DISKUS	Tier 2	QL (1 inhaler per 30 days)
STIOLTO RESPIMAT	Tier 2	QL (3 inhalers per 90 days)
STRIVERDI RESPIMAT	Tier 3	PA
<i>terbutaline oral</i>	Tier 1	
TRELEGY ELLIPTA	Tier 2	QL (3 inhalers per 90 days)
VENTOLIN HFA	Tier 2	QL (2 inhalers per 30 days)
XOPENEX HFA	Tier 2	QL (6 inhalers per 90 days)
<b>VASODILATING AGENTS (RESPIRATORY TRACT)</b>		
ADCIRCA	Tier 3	PA
ADEMPAS	Tier 3	PA
ALYQ	Tier 2	PA
<i>ambrisentan</i>	Tier 2	PA
<i>bosentan</i>	Tier 3	PA
LETAIRIS	Tier 3	PA
LIQREV	Tier 3	PA
OPSUMIT	Tier 2	PA
ORENITRAM	Tier 3	PA
ORENITRAM MONTH 1 TITRATION KT	Tier 3	PA
ORENITRAM MONTH 2 TITRATION KT	Tier 3	PA
ORENITRAM MONTH 3 TITRATION KT	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.



<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
REVATIO ORAL	Tier 3	PA
<i>sildenafil (pulm.hypertension) oral</i>	Tier 2	PA
<i>tadalafil (pulm. hypertension)</i>	Tier 2	PA
TADLIQ	Tier 3	PA; AGE (Min 18 Years)
TRACLEER ORAL TABLET	Tier 2	PA
TRACLEER ORAL TABLET FOR SUSPENSION	Tier 3	PA
TYVASO	Tier 2	PA
TYVASO DPI INHALATION CARTRIDGE WITH INHALER 16 MCG, 16 MCG (112)- 32 MCG (84), 16(112)-32(112) -48(28) MCG, 32 MCG, 48 MCG, 64 MCG	Tier 2	PA
TYVASO INSTITUTIONAL START KIT	Tier 2	PA
TYVASO REFILL KIT	Tier 2	PA
TYVASO STARTER KIT	Tier 2	PA
UPTRAVI ORAL	Tier 2	PA
<b>XANTHINE DERIVATIVES</b>		
<i>theophylline oral elixir</i>	Tier 1	
<i>theophylline oral solution</i>	Tier 1	
<i>theophylline oral tablet extended release 12 hr 300 mg, 450 mg</i>	Tier 1	
<i>theophylline oral tablet extended release 24 hr</i>	Tier 1	
<b>SKIN AND MUCOUS MEMBRANE AGENTS</b>		
<b>ALLYLAMINES (SKIN AND MUCOUS MEMBRANE)</b>		
<i>naftifine topical cream</i>	Tier 3	PA
NAFTIN TOPICAL GEL	Tier 3	PA
<i>terbinafine hcl oral</i>	Tier 2	QL (84 tablets per 1 fill)
<i>terbinafine hcl topical</i>	Tier 1	
<b>ANTIBACTERIALS (84:04)</b>		
ACANYA TOPICAL GEL WITH PUMP	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>bacitracin topical</i>	Tier 1	
<i>bacitracin zinc</i>	Tier 1	
CENTANY	Tier 3	PA
CENTANY AT	Tier 3	PA
CLEOCIN VAGINAL CREAM	Tier 3	PA
CLEOCIN VAGINAL SUPPOSITORY	Tier 2	
<i>clindamycin hcl</i>	Tier 1	
CLINDAMYCIN PEDIATRIC	Tier 1	AGE (Max 12 Years)
<i>clindamycin phosphate topical solution</i>	Tier 1	QL (180 ML per 30 dayss)
<i>clindamycin phosphate topical swab</i>	Tier 1	
<i>clindamycin phosphate vaginal</i>	Tier 2	
<i>clindamycin-benzoyl peroxide topical gel</i>	Tier 2	
<i>clindamycin-benzoyl peroxide topical gel with pump 1.2 %(1 % base) -3.75 %</i>	Tier 1	PA
<i>clindamycin-benzoyl peroxide topical gel with pump 1-5 %, 1.2-2.5 %</i>	Tier 2	
CLINDESSE	Tier 2	
<i>doxycycline hyclate oral capsule</i>	Tier 1	
<i>doxycycline hyclate oral tablet 100 mg</i>	Tier 1	
<i>doxycycline monohydrate oral capsule 100 mg, 50 mg</i>	Tier 1	
<i>doxycycline monohydrate oral suspension for reconstitution</i>	Tier 1	
<i>doxycycline monohydrate oral tablet 100 mg, 50 mg</i>	Tier 1	
E.E.S. 400 ORAL TABLET	Tier 3	PA
E.E.S. GRANULES	Tier 3	PA
ERYPED 200	Tier 3	PA
ERYPED 400	Tier 3	PA
ERY-TAB	Tier 3	PA
ERYTHROCIN (AS STEARATE) ORAL TABLET 250 MG	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug Name	Tier	Restrictions/Limits
<i>erythromycin ethylsuccinate oral suspension for reconstitution 200 mg/5 ml</i>	Tier 2	
<i>erythromycin ethylsuccinate oral suspension for reconstitution 400 mg/5 ml</i>	Tier 3	PA
<i>erythromycin ethylsuccinate oral tablet</i>	Tier 2	
<i>erythromycin oral</i>	Tier 3	PA
<i>erythromycin with ethanol topical solution</i>	Tier 1	
<i>erythromycin-benzoyl peroxide</i>	Tier 1	
FLAGYL ORAL CAPSULE	Tier 3	PA
<i>gentamicin topical</i>	Tier 1	
<i>levofloxacin oral solution</i>	Tier 2	
<i>levofloxacin oral tablet 250 mg, 500 mg</i>	Tier 2	QL (14 tablets per 1 fill)
<i>levofloxacin oral tablet 750 mg</i>	Tier 2	QL (28 tablets per 1 fill)
LIKMEZ	Tier 3	PA
<i>metronidazole oral capsule</i>	Tier 3	PA
<i>metronidazole oral tablet</i>	Tier 2	
<i>moxifloxacin ophthalmic (eye) drops</i>	Tier 2	
<i>moxifloxacin ophthalmic (eye) drops, viscous</i>	Tier 3	PA
<i>moxifloxacin oral</i>	Tier 3	PA; QL (14 tablets per 1 fill)
<i>mupirocin</i>	Tier 2	
<i>mupirocin calcium</i>	Tier 3	PA
<i>neomycin</i>	Tier 2	
NEUAC	Tier 3	PA
NEUAC KIT	Tier 3	PA
ONEXTON	Tier 3	PA
<i>polymyxin b sulf-trimethoprim</i>	Tier 1	
TRIPLE ANTIBIOTIC	Tier 1	
VIGAMOX	Tier 3	PA
XACIATO	Tier 3	PA; AGE (Min 12 Years)
XEPI	Tier 3	PA; QL (60 GM per 30 days)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug Name	Tier	Restrictions/Limits
<b>ANTIPROLIFERANTS</b>		
<i>bexarotene</i>	Tier 1	
<i>fluorouracil topical cream</i>	Tier 1	
<i>imiquimod topical cream in packet 5 %</i>	Tier 1	
TARGRETIN TOPICAL	Tier 1	
<b>ANTIPRURITICS AND LOCAL ANESTHETICS</b>		
ASPERCREME (LIDOCAINE HCL) TOPICAL CREAM	Tier 1	QL (153 GM per 30 dayss)
ASPERCREME (LIDOCAINE) TOPICAL ADHESIVE PATCH,MEDICATED	Tier 1	QL (30 patches per 30 days)
<i>lidocaine hcl topical cream 3 %</i>	Tier 1	QL (85 GM per 30 days)
LIDOCAINE PAIN RELIEF TOPICAL ADHESIVE PATCH,MEDICATED	Tier 1	QL (30 patches per 30 days)
<i>lidocaine topical adhesive patch,medicated 4 %</i>	Tier 1	QL (30 patches per 30 days)
<i>lidocaine topical adhesive patch,medicated 5 %</i>	Tier 1	PA; QL (3 patches per 1 day)
<i>lidocaine topical ointment</i>	Tier 1	QL (100 GM per 30 days)
<i>lidocaine-prilocaine topical cream</i>	Tier 1	QL (1 GM per 1 day)
<i>phenazopyridine oral tablet 100 mg, 200 mg</i>	Tier 1	
<b>ANTIVIRALS (SKIN AND MUCOUS MEMBRANE)</b>		
<i>acyclovir oral</i>	Tier 2	
<i>acyclovir topical cream</i>	Tier 3	PA
<i>acyclovir topical ointment</i>	Tier 2	
DENAVIR	Tier 2	
<i>docosanol</i>	Tier 1	
<i>penciclovir</i>	Tier 3	PA
XERESE	Tier 3	PA
ZOVIRAX ORAL SUSPENSION	Tier 3	PA
ZOVIRAX TOPICAL CREAM	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we willcover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that iscovered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs firstbefore other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain agerequirement.

Drug Name	Tier	Restrictions/Limits
ZOVIRAX TOPICAL OINTMENT	Tier 3	PA
<b>ASTRINGENTS</b>		
BEVESPI AEROSPHERE	Tier 2	QL (3 inhalers per 90 days)
<i>glycopyrrolate oral solution</i>	Tier 1	AGE (Max 12 Years)
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	Tier 1	
<b>AZOLES (SKIN AND MUCOUS MEMBRANE)</b>		
3-DAY VAGINAL	Tier 1	
ANTIFUNGAL (CLOTRIMAZOLE)	Tier 2	
ANTIFUNGAL (MICONAZOLE) TOPICAL CREAM	Tier 2	
CLOTRIMAZOLE 3 DAY	Tier 1	
<i>clotrimazole mucous membrane</i>	Tier 2	
<i>clotrimazole topical</i>	Tier 2	
<i>clotrimazole vaginal</i>	Tier 1	
CLOTRIMAZOLE-3	Tier 1	
CLOTRIMAZOLE-7	Tier 1	
<i>clotrimazole-betamethasone topical cream</i>	Tier 2	
<i>clotrimazole-betamethasone topical lotion</i>	Tier 3	PA
<i>econazole</i>	Tier 3	PA
ERTACZO	Tier 3	PA
EXTINA	Tier 3	PA
JUBLIA	Tier 3	PA; AGE (Min 6 Years)
<i>ketoconazole oral</i>	Tier 2	
<i>ketoconazole topical cream</i>	Tier 2	
<i>ketoconazole topical foam</i>	Tier 3	PA
<i>ketoconazole topical shampoo</i>	Tier 2	
KETODAN	Tier 3	PA
KETODAN KIT	Tier 3	PA
LOTRIMIN AF (CLOTRIMAZOLE) TOPICAL CREAM	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>luliconazole</i>	Tier 3	PA
LUZU	Tier 3	PA
<i>miconazole nitrate topical cream</i>	Tier 2	
<i>miconazole nitrate vaginal comb pack, prefill appl, cream</i>	Tier 1	
<i>miconazole nitrate vaginal cream</i>	Tier 1	
<i>miconazole nitrate vaginal suppository</i>	Tier 1	
<i>miconazole nitrate-zinc ox-pet</i>	Tier 3	PA
MICONAZOLE-3 PREFIL, CREAM, WIPE	Tier 1	
MICONAZOLE-3 VAGINAL COMB PACK, PREFILL APPL, CREAM	Tier 1	
MICONAZOLE-3 VAGINAL KIT	Tier 1	
MICONAZOLE-7	Tier 1	
MONISTAT 3 VAGINAL COMB PACK, PREFILL APPL, CREAM	Tier 1	
MONISTAT 3 VAGINAL KIT	Tier 1	
MONISTAT 7 VAGINAL CREAM	Tier 1	
MYCOZYL AC	Tier 3	PA
ORAVIG	Tier 3	PA
<i>oxiconazole</i>	Tier 3	PA
OXISTAT TOPICAL LOTION	Tier 3	PA
<i>terconazole vaginal cream</i>	Tier 1	
VUSION	Tier 3	PA
<b>BASIC LOTIONS AND LINIMENTS</b>		
<i>ammonium lactate topical lotion</i>	Tier 1	QL (225 GM per 30 dayss)
<b>BASIC OINTMENTS AND PROTECTANTS</b>		
<i>ammonium lactate topical cream</i>	Tier 1	QL (140 GM per 30 dayss)
<i>calcipotriene scalp</i>	Tier 1	PA; AGE (Min 2 Years)
<i>calcipotriene topical cream</i>	Tier 1	PA; AGE (Min 2 Years)
<i>calcipotriene topical ointment</i>	Tier 1	PA; AGE (Min 2 Years)
VTAMA	Tier 1	PA; QL (60 GM per 1 Fill); AGE (Min 18 Years)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug Name	Tier	Restrictions/Limits
<b>BENZYLAMINES (SKIN AND MUCOUS MEMBRANE)</b>		
<i>butenafine</i>	Tier 3	PA
MENTAX	Tier 3	PA
<b>CELL STIMULANTS AND PROLIFERANTS</b>		
<i>finasteride oral tablet 5 mg</i>	Tier 2	
PROSCAR	Tier 3	PA
<i>tretinoin topical cream 0.025 %, 0.05 %</i>	Tier 1	QL (0.7 GM per 1 day); AGE (Max 30 Years)
<b>CORTICOSTEROIDS (SKIN, MUCOUS MEMBRANE)</b>		
<i>alclometasone</i>	Tier 3	PA
ANTI-ITCH (HC) TOPICAL CREAM	Tier 2	
APEXICON E	Tier 3	PA
BESER	Tier 3	PA
BESER KIT	Tier 3	PA
<i>betamethasone dipropionate</i>	Tier 2	
<i>betamethasone valerate topical cream</i>	Tier 2	
<i>betamethasone valerate topical foam</i>	Tier 3	PA
<i>betamethasone valerate topical lotion</i>	Tier 2	
<i>betamethasone valerate topical ointment</i>	Tier 2	
<i>betamethasone, augmented</i>	Tier 3	PA
BRYHALI	Tier 3	PA
<i>clobetasol scalp</i>	Tier 2	
<i>clobetasol topical cream</i>	Tier 2	
<i>clobetasol topical foam</i>	Tier 3	PA
<i>clobetasol topical gel</i>	Tier 2	
<i>clobetasol topical lotion</i>	Tier 3	PA
<i>clobetasol topical ointment</i>	Tier 2	
<i>clobetasol topical shampoo</i>	Tier 3	PA
<i>clobetasol topical spray, non-aerosol</i>	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.



<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>clobetasol-emollient</i>	Tier 3	PA
CLOBEX	Tier 3	PA
<i>clocortolone pivalate</i>	Tier 3	PA
CLODAN	Tier 3	PA
CLODAN KIT	Tier 3	PA
<i>clotrimazole-betamethasone topical cream</i>	Tier 2	
<i>clotrimazole-betamethasone topical lotion</i>	Tier 3	PA
DERMA-SMOOTH/FS BODY OIL	Tier 3	PA
DERMA-SMOOTH/FS SCALP OIL	Tier 3	PA
<i>desonide topical cream</i>	Tier 3	PA
<i>desonide topical lotion</i>	Tier 3	PA
<i>desonide topical ointment</i>	Tier 3	PA
DESOWEN TOPICAL CREAM	Tier 3	PA
<i>desoximetasone</i>	Tier 3	PA
<i>diflorasone</i>	Tier 3	PA
DIPROLENE (AUGMENTED) TOPICAL OINTMENT	Tier 3	PA
<i>fluocinolone</i>	Tier 3	PA
<i>fluocinolone and shower cap</i>	Tier 3	PA
<i>fluocinonide</i>	Tier 3	PA
FLUOCINONIDE-E	Tier 3	PA
<i>fluocinonide-emollient</i>	Tier 3	PA
<i>flurandrenolide</i>	Tier 3	PA
<i>fluticasone propionate topical cream</i>	Tier 2	
<i>fluticasone propionate topical lotion</i>	Tier 3	PA
<i>fluticasone propionate topical ointment</i>	Tier 2	
<i>halcinonide</i>	Tier 3	PA
<i>halobetasol propionate topical cream</i>	Tier 2	
<i>halobetasol propionate topical foam</i>	Tier 3	PA
<i>halobetasol propionate topical ointment</i>	Tier 2	
HALOG	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>hydrocortisone acetate topical cream</i>	Tier 2	
<i>hydrocortisone acetate topical ointment</i>	Tier 2	
<i>hydrocortisone butyrate</i>	Tier 3	PA
<i>hydrocortisone topical cream</i>	Tier 2	
<i>hydrocortisone topical cream with perineal applicator 2.5 %</i>	Tier 1	
<i>hydrocortisone topical lotion 2.5 %</i>	Tier 2	
<i>hydrocortisone topical ointment</i>	Tier 2	
<i>hydrocortisone valerate</i>	Tier 3	PA
<i>hydrocortisone-aloe vera topical cream 1 %</i>	Tier 3	PA
KENALOG TOPICAL	Tier 3	PA
LOCOID LIPOCREAM	Tier 3	PA
LOCOID TOPICAL LOTION	Tier 3	PA
<i>mometasone topical</i>	Tier 2	
OLUX	Tier 3	PA
PANDEL	Tier 3	PA
<i>prednicarbate</i>	Tier 3	PA
PROCTOCORT TOPICAL	Tier 3	PA
PROCTOSOL HC TOPICAL	Tier 1	
SERNIVO	Tier 3	PA
SYNALAR	Tier 3	PA
SYNALAR CREAM KIT	Tier 3	PA
SYNALAR OINTMENT KIT	Tier 3	PA
SYNALAR TS	Tier 3	PA
TEXACORT	Tier 3	PA
TOPICORT	Tier 3	PA
TOVET EMOLLIENT	Tier 3	PA
TOVET KIT	Tier 3	PA
<i>triamcinolone acetonide dental</i>	Tier 1	QL (5 GM per 30 dayss)
<i>triamcinolone acetonide topical aerosol</i>	Tier 3	PA
<i>triamcinolone acetonide topical cream</i>	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
<i>triamcinolone acetonide topical lotion</i>	Tier 2	
<i>triamcinolone acetonide topical ointment</i>	Tier 2	
TRIANEX	Tier 3	PA
TRIDERM TOPICAL CREAM 0.1 %	Tier 2	
ULTRAVATE TOPICAL LOTION	Tier 3	PA
VANOS	Tier 3	PA
XERESE	Tier 3	PA
<b>HYDROXYPYRIDONES (SKIN, MUCOUS MEMBRANE)</b>		
CICLODAN	Tier 3	PA
CICLODAN KIT	Tier 3	PA
<i>ciclopirox topical cream</i>	Tier 2	
<i>ciclopirox topical gel</i>	Tier 3	PA
<i>ciclopirox topical shampoo</i>	Tier 3	PA
<i>ciclopirox topical solution</i>	Tier 2	
<i>ciclopirox topical suspension</i>	Tier 3	PA
<i>ciclopirox-ure-camph-menth-euc</i>	Tier 3	PA
LOPROX (AS OLAMINE)	Tier 3	PA
LOPROX KIT	Tier 3	PA
<b>IMMUNOMODULATORY AGENTS (84:06)</b>		
ADBRY SUBCUTANEOUS SYRINGE	Tier 3	PA; QL (4 syringes per 28 days)
BIMZELX	Tier 3	PA
BIMZELX AUTOINJECTOR	Tier 3	PA
ELIDEL	Tier 2	PA; QL (30 GM per 30 days); AGE (Min 2 Years)
ILUMYA	Tier 3	PA
<i>pimecrolimus</i>	Tier 2	PA; QL (30 GM per 30 days); AGE (Min 2 Years)
SILIQ	Tier 3	PA
<i>sirolimus oral tablet</i>	Tier 1	
SKYRIZI SUBCUTANEOUS PEN INJECTOR	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug Name	Tier	Restrictions/Limits
SKYRIZI SUBCUTANEOUS SYRINGE 150 MG/ML	Tier 3	PA
SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR	Tier 3	PA
<i>tacrolimus topical ointment 0.03 %</i>	Tier 3	PA; QL (30 GM per 30 days); AGE (Min 2 Years)
<i>tacrolimus topical ointment 0.1 %</i>	Tier 3	PA; QL (30 GM per 30 days); AGE (Min 16 Years)
TREMFYA	Tier 3	PA
<b>JANUS KINASE INHIBITORS</b>		
CIBINQO	Tier 3	PA; AGE (Min 12 Years)
DALIRESP	Tier 3	PA
JAKAFI	Tier 1	
LITFULO	Tier 1	PA; QL (1 EA per 1 day); AGE (Min 12 Years and Max 150 Years)
OPZELURA	Tier 3	PA; QL (240 GM per 30 days); AGE (Min 12 Years)
<i>roflumilast</i>	Tier 1	PA
SOTYKTU	Tier 3	PA; QL (1 tablet per 1 day); AGE (Min 18 Years)
ZORYVE TOPICAL CREAM	Tier 1	PA; AGE (Min 6 Years)
ZORYVE TOPICAL FOAM	Tier 1	PA
<b>KERATOLYTIC AGENTS</b>		
ACANYA TOPICAL GEL WITH PUMP	Tier 3	PA
<i>acitretin oral capsule 10 mg, 17.5 mg, 25 mg</i>	Tier 1	PA; QL (2 capsules per 1 day)
<i>adapalene topical gel 0.1 %</i>	Tier 1	QL (45 GM per 30 days)
<i>adapalene topical gel 0.3 %</i>	Tier 1	QL (1.5 GM per 1 day); AGE (Max 30 Years)
AMNESTEEM	Tier 1	PA; QL (2 capsules per 1 day)
<i>benzoyl peroxide topical cleanser 10 %, 5 %</i>	Tier 1	
<i>benzoyl peroxide topical gel 10 %</i>	Tier 1	QL (3.78 GM per 1 day)
<i>benzoyl peroxide topical gel 5 %</i>	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
CICLODAN KIT TOPICAL SOLUTION	Tier 3	PA
<i>ciclopirox-ure-camph-menth-euc</i>	Tier 3	PA
CLARAVIS	Tier 1	PA; QL (2 capsules per 1 day)
<i>clindamycin-benzoyl peroxide topical gel</i>	Tier 2	
<i>clindamycin-benzoyl peroxide topical gel with pump 1.2 %(1 % base) -3.75 %</i>	Tier 1	PA
<i>clindamycin-benzoyl peroxide topical gel with pump 1-5 %, 1.2-2.5 %</i>	Tier 2	
CREAMY ACNE FACE	Tier 1	
DIFFERIN TOPICAL GEL 0.1 %	Tier 1	QL (45 GM per 30 days)
<i>isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	Tier 1	PA; QL (2 capsules per 1 day)
NEUAC	Tier 3	PA
NEUAC KIT	Tier 3	PA
ONEXTON	Tier 3	PA
<i>podofilox topical solution</i>	Tier 1	
<i>sulfacetamide sodium-sulfur topical cleanser 10-5 % (w/w)</i>	Tier 1	
<i>tazarotene topical cream</i>	Tier 1	PA
<i>tazarotene topical gel</i>	Tier 1	PA
ZENATANE	Tier 1	PA; QL (2 capsules per 1 day)
<b>LOCAL ANTI-INFECTIVES, MISCELLANEOUS</b>		
<i>alcohol swabs</i>	Tier 1	
BD ALCOHOL SWABS	Tier 1	
EASY TOUCH ALCOHOL PREP PADS	Tier 1	
<i>selenium sulfide topical lotion</i>	Tier 1	
<i>silver sulfadiazine</i>	Tier 1	
SSD	Tier 1	
<i>sulfacetamide sodium-sulfur topical cleanser 10-5 % (w/w)</i>	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug Name	Tier	Restrictions/Limits
<b>NONSTEROIDAL ANTI-INFLAMMAT.AGENTS(SKIN)</b>		
<i>diclofenac epolamine</i>	Tier 3	PA; QL (2 patches per 1 day)
<i>diclofenac potassium oral capsule</i>	Tier 3	PA
<i>diclofenac potassium oral tablet</i>	Tier 3	PA
<i>diclofenac sodium oral tablet extended release 24 hr</i>	Tier 3	PA
<i>diclofenac sodium oral tablet, delayed release (dr/ec)</i>	Tier 2	
<i>diclofenac sodium topical drops</i>	Tier 2	
<i>diclofenac sodium topical gel 1 %</i>	Tier 2	
<i>diclofenac sodium topical gel 3 %</i>	Tier 1	
<i>diclofenac sodium topical solution in metered-dose pump</i>	Tier 3	PA
FLECTOR	Tier 3	PA; QL (2 patches per 1 day)
LICART	Tier 3	PA; QL (15 patches per 30 days)
LOFENA	Tier 3	PA
PENNSAID	Tier 3	PA
ZIPSOR	Tier 3	PA
ZORVOLEX	Tier 3	PA
<b>OXABOROLES</b>		
KERYDIN	Tier 3	PA; AGE (Min 6 Years)
<i>tavaborole</i>	Tier 3	PA; AGE (Min 6 Years)
<b>PHOSPHODIESTERASE-4 INHIBIT</b>		
EUCRISA	Tier 2	PA; QL (100 GM per 30 days); AGE (Min 3 Months)
<b>POLYENES (SKIN AND MUCOUS MEMBRANE)</b>		
KLAYESTA	Tier 2	
NYAMYC	Tier 2	
<i>nystatin topical</i>	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug Name	Tier	Restrictions/Limits
<i>nystatin-triamcinolone</i>	Tier 2	
NYSTOP	Tier 2	
<b>SCABICIDES AND PEDICULICIDES</b>		
LICE KILLING	Tier 1	QL (59 ML per 30 dayss)
LICE PYRINYL SHAMPOO	Tier 1	QL (59 ML per 30 dayss)
LICE TREATMENT	Tier 1	QL (59 ML per 30 dayss)
LICE TREATMENT (PERMETHRIN)	Tier 1	QL (59 ML per 30 dayss)
<i>malathion</i>	Tier 1	QL (1.97 ML per 1 day); ST
NIX CREME RINSE	Tier 1	QL (59 ML per 30 dayss)
<i>permethrin</i>	Tier 1	QL (2 GM per 1 day)
RID LICE KILLING	Tier 1	QL (59 ML per 30 dayss)
<i>spinosad</i>	Tier 1	QL (240 ML per 180 dayss); ST
<b>SKIN AND MUCOUS MEMBRANE AGENTS, MISC.</b>		
<i>adapalene-benzoyl peroxide topical gel with pump 0.1-2.5 %</i>	Tier 1	QL (1.5 GM per 1 day); AGE (Max 30 Years)
<i>calcitriol topical</i>	Tier 1	PA; AGE (Min 2 Years)
CICLODAN KIT TOPICAL COMBO PACK	Tier 3	PA
DUPIXENT PEN	Tier 2	PA; AGE (Min 2 Years)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 200 MG/1.14 ML, 300 MG/2 ML	Tier 2	PA
ENDARI	Tier 1	PA; QL (180 packets per 30 dayss); AGE (Min 5 Years)
FLAGYL ORAL CAPSULE	Tier 3	PA
LIKMEZ	Tier 3	PA
LOPROX KIT	Tier 3	PA
<i>metronidazole oral capsule</i>	Tier 3	PA
<i>metronidazole oral tablet</i>	Tier 2	
OTEZLA	Tier 3	PA
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we willcover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that iscovered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs firstbefore other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain agerequirement.



Drug Name	Tier	Restrictions/Limits
<b>THIOCARBAMATES(SKIN AND MUCOUS MEMBRANE)</b>		
ANTIFUNGAL (TOLNAFTATE) TOPICAL CREAM	Tier 2	
<i>tolnaftate topical cream</i>	Tier 2	
<i>tolnaftate topical powder</i>	Tier 2	
<b>SMOOTH MUSCLE RELAXANTS</b>		
<b>ANTIMUSCARINICS</b>		
<i>darifenacin</i>	Tier 3	PA
DETROL	Tier 3	PA
DETROL LA	Tier 3	PA
<i>fesoterodine</i>	Tier 3	PA
<i>flavoxate</i>	Tier 3	PA
GELNIQUE TRANSDERMAL GEL IN PACKET	Tier 3	PA
<i>oxybutynin chloride</i>	Tier 2	
OXYTROL	Tier 3	PA
OXYTROL FOR WOMEN	Tier 1	
<i>solifenacin</i>	Tier 2	
<i>tolterodine</i>	Tier 3	PA
TOVIAZ	Tier 2	
<i>trospium</i>	Tier 3	PA
VESICARE	Tier 3	PA
VESICARE LS	Tier 3	PA
<b>RESPIRATORY SMOOTH MUSCLE RELAXANTS</b>		
<i>theophylline oral elixir</i>	Tier 1	
<i>theophylline oral solution</i>	Tier 1	
<i>theophylline oral tablet extended release 12 hr 300 mg, 450 mg</i>	Tier 1	
<i>theophylline oral tablet extended release 24 hr</i>	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug Name	Tier	Restrictions/Limits
<b>SELECTIVE BETA-3-ADRENERGIC AGONISTS</b>		
GEMTESA	Tier 3	PA
<i>mirabegron</i>	Tier 3	PA
MYRBETRIQ	Tier 3	PA
<b>VITAMINS</b>		
<b>MULTIVITAMIN PREPARATIONS</b>		
A THRU Z	Tier 1	
A THRU Z ADVANCED FORMULA	Tier 1	
A THRU Z MEN'S ULTIMATE	Tier 1	
A THRU Z SELECT 50PLUS FORMULA	Tier 1	
A THRU Z SELECT ORAL TABLET 300-60-600-300 MCG, 500-300-250 MCG	Tier 1	
A THRU Z SELECT WOMEN'S	Tier 1	
ABC PLUS	Tier 1	
ADULT MULTIVITAMIN GUMMIES ORAL TABLET,CHEWABLE 200 MCG	Tier 1	
ADULT ONE DAILY GUMMIES	Tier 1	
BACMIN	Tier 1	
BIO-35, GLUTEN FREE	Tier 1	
BIOCEL (WITH LUTEIN)	Tier 1	
BODY, HAIR, SKIN AND NAILS	Tier 1	
CENTRAL-VITE WOMEN'S MATURE	Tier 1	
CENTRAVITES	Tier 1	
CENTRUM CHEWABLES ORAL TABLET,CHEWABLE 8 MG-400 MCG- 10 MCG	Tier 1	
CENTRUM COMPLETE	Tier 1	
CENTRUM MEN	Tier 1	
CENTRUM SILVER ORAL TABLET	Tier 1	
CENTRUM SILVER ULTRA MEN'S	Tier 1	
CENTRUM SILVER WOMEN	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
CENTRUM SPECIALIST HEART	Tier 1	
CENTRUM ULTRA MEN'S	Tier 1	
CENTURY	Tier 1	
CENTURY MATURE	Tier 1	
CERTA PLUS	Tier 1	
CERTAVITE SENIOR	Tier 1	
CERTAVITE-ANTIOXIDANT	Tier 1	
CLASSIC PRENATAL	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
COMPLETE MULTIVITAMIN-MINERAL ORAL TABLET	Tier 1	
COMPLETE MV ADULT 50 PLUS	Tier 1	
COMPLETENATE	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
CORVITE FREE	Tier 1	
DAILY GUMMIES	Tier 1	
DAILY MULTIPLE FOR WOMEN	Tier 1	
DAILY MULTIVITAMIN	Tier 1	
DAILY MULTIVITAMIN WITH IRON	Tier 1	
DAILY VALUE	Tier 1	
DAILY VITAMIN FORMULA	Tier 1	
DAILY VITAMIN FORMULA-IRON	Tier 1	
DAILY VITAMIN FORMULA-MINERALS	Tier 1	
DAILY VITAMIN WITH IRON	Tier 1	
DAILY VITES/IRON	Tier 1	
DAILY-VITE	Tier 1	
DAILY-VITE (WITH FOLIC ACID)	Tier 1	
DECUBI VITE	Tier 1	
DEKAS ESSENTIAL	Tier 1	
DEKAS PLUS (FOLIC ACID)	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug Name	Tier	Restrictions/Limits
DEKAS PLUS LIQUID	Tier 1	
DIABETES HEALTH FORMULA	Tier 1	
ESSENTIA	Tier 1	
ESSENTIAL MAN	Tier 1	
ESSENTIAL MAN 50 PLUS	Tier 1	
ESSENTIAL WOMAN 50 PLUS	Tier 1	
EYE HEALTH PLUS LUTEIN	Tier 1	
FORTAVIT	Tier 1	
FREEDAVITE	Tier 1	
HAIR, SKIN AND NAILS-ARGAN OIL	Tier 1	
HAIR,SKIN AND NAILS	Tier 1	
HAIR,SKIN AND NAILS(FA-BIOTIN) ORAL TABLET 66.7-1,000 MCG	Tier 1	
ICAPS MV	Tier 1	
K-PAX IMMUNE SUPPORT	Tier 1	
MEGA MULTI FOR WOMEN	Tier 1	
MEGA MULTIVITAMIN FOR MEN	Tier 1	
MEN'S DAILY	Tier 1	
MEN'S MULTIVITAMIN GUMMIES ORAL TABLET,CHEWABLE 200 MCG	Tier 1	
MEN'S ONE DAILY	Tier 1	
MONOCAPS	Tier 1	
MULTI COMPLETE WITH IRON	Tier 1	
MULTI FOR HER ORAL TABLET	Tier 1	
MULTI-DAY WITH IRON	Tier 1	
MULTIPLE VITAMIN-MINERALS	Tier 1	
MULTIPLE VITAMINS	Tier 1	
MULTI-VIT WITH FLUORIDE-IRON	Tier 1	QL (2 ML per 1 day); AGE (Max 12 Years)
<i>multivitamin</i>	Tier 1	
MULTI-VITAMIN WITH FLUORIDE ORAL DROPS	Tier 1	QL (2 ML per 1 day); AGE (Max 12 Years)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug Name	Tier	Restrictions/Limits
MULTI-VITAMIN WITH FLUORIDE ORAL TABLET,CHEWABLE 0.25 MG	Tier 1	QL (1 tablet per 1 day)
MULTI-VITAMIN WITH FLUORIDE ORAL TABLET,CHEWABLE 0.5 MG, 1 MG	Tier 1	QL (1 tablet per 1 day); AGE (Max 12 Years)
<i>multivitamin with iron</i>	Tier 1	
<i>multivit-min-iron fum-folic ac</i>	Tier 1	
MVC-FLUORIDE	Tier 1	QL (1 tablet per 1 day); AGE (Max 12 Years)
<i>mv-min-folic acid-lutein</i>	Tier 1	
MVW COMPLETE FORMUL MULTIVIT ORAL CAPSULE 750-500 UNIT-MCG	Tier 1	
MVW COMPLETE FORMULATION D3000 ORAL TABLET,CHEWABLE	Tier 1	
MY-VITALIFE	Tier 1	
NANO VM 1-3	Tier 1	
NANO VM 4-8	Tier 1	
NANOVM 9-18	Tier 1	
NANOVM T-F	Tier 1	
NESTABS	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
NESTABS DHA	Tier 1	QL (2 capsules per 1 day); AGE (Min 12 Years and Max 55 Years)
NEWGEN	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
OCUTABS	Tier 1	
OMNICAP	Tier 1	
ONCOVITE	Tier 1	
ONE DAILY	Tier 1	
ONE DAILY CALCIUM/IRON	Tier 1	
ONE DAILY COMPLETE	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
ONE DAILY ENERGY ORAL TABLET	Tier 1	
ONE DAILY ESSENTIAL ORAL TABLET , 0.4 MG, 400 MCG	Tier 1	
ONE DAILY FOR MEN	Tier 1	
ONE DAILY FOR MEN 50 PLUS ADV	Tier 1	
ONE DAILY FOR WOMEN	Tier 1	
ONE DAILY HEALTHY WEIGHT	Tier 1	
ONE DAILY MAXIMUM	Tier 1	
ONE DAILY MEN'S 50 PLUS MEMORY	Tier 1	
ONE DAILY MULTI-VIT W-MINERAL ORAL TABLET	Tier 1	
ONE DAILY MULTIVITAMIN ORAL TABLET	Tier 1	
ONE DAILY MULTIVIT-IRON(FOLIC)	Tier 1	
ONE DAILY PLUS IRON	Tier 1	
ONE DAILY PLUS MINERALS	Tier 1	
ONE DAILY WOMEN 50 PLUS	Tier 1	
ONE DAILY WOMENS 50 PLUS	Tier 1	
ONE DAILY WOMEN'S ORAL TABLET 18 MG IRON-400 MCG-450 MG CA	Tier 1	
ONE-A-DAY ENERGY	Tier 1	
ONE-A-DAY ESSENTIAL	Tier 1	
ONE-A-DAY MAXIMUM FORMULA	Tier 1	
ONE-A-DAY MEN VITACRAVES	Tier 1	
ONE-A-DAY MENOPAUSE FORMULA	Tier 1	
ONE-A-DAY MEN'S 50PLUS(GINKGO)	Tier 1	
ONE-A-DAY MEN'S MULTIVITAMIN	Tier 1	
ONE-A-DAY TEEN ADVANTAGE	Tier 1	
ONE-A-DAY VITACRAVES	Tier 1	
ONE-A-DAY VITACRAVES IMMUNITY	Tier 1	
ONE-A-DAY VITACRAVES OMEGA-3	Tier 1	
ONE-A-DAY WEIGHTSMART	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug Name	Tier	Restrictions/Limits
ONE-A-DAY WOMEN VITACRAVES	Tier 1	
ONE-A-DAY WOMEN'S ACTIVE	Tier 1	
ONE-A-DAY WOMEN'S HEALTHY SKIN	Tier 1	
ONE-A-DAY WOMEN'S PETITES	Tier 1	
OPTISOURCE	Tier 1	
OPURITY MULTIVITAMIN	Tier 1	
<i>pnv cmb#95-ferrous fumarate-fa</i>	Tier 1	QL (1 tablet per 1 day)
PRENATABS RX	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL COMPLETE	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL FORMULA ORAL TABLET 28 MG IRON- 800 MCG	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL MULTI-DHA(WITH VIT K)	Tier 1	AGE (Min 12 Years and Max 55 Years)
PRENATAL MULTIVITAMINS	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL ORAL TABLET 28 MG IRON- 800 MCG	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL PLUS (CALCIUM CARB)	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL TABLET	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL VITAMIN PLUS LOW IRON	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.



<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
PRENATAL VITAMIN WITH MINERALS	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PROCERV HP	Tier 1	
PRORENAL QD	Tier 1	
PROTECT CARDIO AF	Tier 1	
PROTECT PLUS SO	Tier 1	
QUINTABS	Tier 1	
QUINTABS-M	Tier 1	
QUINTABS-M IRON FREE	Tier 1	
SE-NATAL-19	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
SENTRY	Tier 1	
SENTRY SENIOR	Tier 1	
SOLO	Tier 1	
SPECTRAVITE ADVANCED FORMULA	Tier 1	
SPECTRAVITE MEN'S	Tier 1	
STRESS FORMULA	Tier 1	
SUNVITE	Tier 1	
SUPER GINSENG MULTIVITAMIN	Tier 1	
SUPER MULTIPLE - LOW IRON	Tier 1	
SUPER THERA VITE M	Tier 1	
TAB-A-VITE MULTIVITAMIN W-IRON ORAL TABLET 15 MG IRON- 400 MCG	Tier 1	
THERA	Tier 1	
THERAGRAN-M PREMIER 50 PLUS	Tier 1	
THERALOGIX COMPANION	Tier 1	
THERA-M ORAL TABLET 27-0.4 MG	Tier 1	
THERANATAL ORAL TABLET	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
THERAPEUTIC-M	Tier 1	
THERA-TABS	Tier 1	
THERATRUM COMPLETE WITH LUTEIN	Tier 1	
TRICARE	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
TRINATAL RX 1	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
TRI-VI-SOL	Tier 1	
TRI-VITAMIN WITH FLUORIDE	Tier 1	QL (2 drops per 1 day); AGE (Max 12 Years)
ULTRA FREEDA	Tier 1	
V-C FORTE	Tier 1	
VIC-FORTE	Tier 1	
VITACEL (WITH LUTEIN)	Tier 1	
VITALEE	Tier 1	
VITAMINS A,C,D AND FLUORIDE ORAL DROPS 0.25 MG FLUOR. (0.55 MG)/ML	Tier 1	QL (2 ML per 1 day); AGE (Max 12 Years)
VITAMINS A-D-E SELENIUM	Tier 1	
VITATRUM	Tier 1	
VITRUM SENIOR ORAL TABLET 500-300-250 MCG	Tier 1	
WESTAB PLUS	Tier 1	
WOMEN'S DAILY FORMULA ORAL TABLET 27-0.4 MG	Tier 1	
WOMEN'S MULTIVITAMIN GUMMIES ORAL TABLET,CHEWABLE 200 MCG	Tier 1	
WOMEN'S ONE DAILY ORAL TABLET 18 MG IRON-400 MCG-500 MG CA	Tier 1	
YELETS	Tier 1	
<b>VITAMIN A</b>		
<i>beta carotene</i>	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug Name	Tier	Restrictions/Limits
DEKAS ESSENTIAL	Tier 1	
TRI-VI-SOL	Tier 1	
TRI-VITAMIN WITH FLUORIDE	Tier 1	QL (2 drops per 1 day); AGE (Max 12 Years)
<i>vitamin a palmitate oral capsule</i>	Tier 1	
VITAMINS A,C,D AND FLUORIDE ORAL DROPS 0.25 MG FLUOR. (0.55 MG)/ML	Tier 1	QL (2 ML per 1 day); AGE (Max 12 Years)
VITAMINS A-D-E SELENIUM	Tier 1	
<b>VITAMIN B COMPLEX</b>		
A THRU Z ADVANCED FORMULA	Tier 1	
A THRU Z MEN'S ULTIMATE	Tier 1	
A THRU Z SELECT 50PLUS FORMULA	Tier 1	
A THRU Z SELECT ORAL TABLET 300-60-600-300 MCG, 500-300-250 MCG	Tier 1	
ABC PLUS	Tier 1	
ADULT MULTIVITAMIN GUMMIES ORAL TABLET,CHEWABLE 200 MCG	Tier 1	
ADULT ONE DAILY GUMMIES	Tier 1	
ALBA-LYBE	Tier 1	
APETEX	Tier 1	
APETIGEN	Tier 1	
ARKALIOX	Tier 1	
B COMPLEX	Tier 1	
B COMPLEX 1 (WITH FOLIC ACID)	Tier 1	
B COMPLEX 100	Tier 1	
B COMPLEX PLUS VITAMIN C	Tier 1	
B COMPLEX W-VIT C	Tier 1	
<i>b complex-vitamin c-folic acid</i>	Tier 1	
B-100 COMPLEX	Tier 1	
BACMIN	Tier 1	
BALANCE B-100 (FOLIC ACID)	Tier 1	
BALANCE B-50 (WITH FOLIC ACID)	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
BALANCED B-100 COMPLEX	Tier 1	
BALANCED B-100 ORAL TABLET	Tier 1	
BALANCED B-50	Tier 1	
B-COMPLEX WITH B-12	Tier 1	
B-COMPLEX WITH VITAMIN C ORAL TABLET 400-500 MCG-MG	Tier 1	
BEELITH	Tier 1	
BIO-35, GLUTEN FREE	Tier 1	
BIOCAL	Tier 1	
BIOCEL (WITH LUTEIN)	Tier 1	
BIOPETIT	Tier 1	
<i>biotin oral capsule 1 mg, 2,500 mcg, 5 mg</i>	Tier 1	
<i>biotin oral tablet</i>	Tier 1	
CENTRAL-VITE WOMEN'S MATURE	Tier 1	
CENTRUM CHEWABLES ORAL TABLET,CHEWABLE 8 MG-400 MCG- 10 MCG	Tier 1	
CENTRUM COMPLETE	Tier 1	
CENTRUM MEN	Tier 1	
CENTRUM SILVER ORAL TABLET	Tier 1	
CENTRUM SILVER ULTRA MEN'S	Tier 1	
CENTRUM SILVER WOMEN	Tier 1	
CENTRUM ULTRA MEN'S	Tier 1	
CENTURY	Tier 1	
CENTURY MATURE	Tier 1	
CERTA PLUS	Tier 1	
CERTAVITE SENIOR	Tier 1	
CERTAVITE-ANTIOXIDANT	Tier 1	
CLASSIC PRENATAL	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug Name	Tier	Restrictions/Limits
COMPLETE MULTIVITAMIN-MINERAL ORAL TABLET	Tier 1	
COMPLETE MV ADULT 50 PLUS	Tier 1	
COMPLETENATE	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
COMPLEX B-100	Tier 1	
COMPLEX B-50	Tier 1	
CORVITE FREE	Tier 1	
<i>cyanocobalamin (vitamin b-12) injection</i>	Tier 1	
DAILY GUMMIES	Tier 1	
DAILY MULTIPLE FOR WOMEN	Tier 1	
DAILY MULTIVITAMIN	Tier 1	
DAILY MULTIVITAMIN WITH IRON	Tier 1	
DAILY VITAMIN FORMULA-IRON	Tier 1	
DAILY-VITE (WITH FOLIC ACID)	Tier 1	
DECUBI VITE	Tier 1	
DEKAS PLUS (FOLIC ACID)	Tier 1	
DIABETES HEALTH FORMULA	Tier 1	
DIALYVITE	Tier 1	
DIALYVITE 3000	Tier 1	
DIALYVITE 5000	Tier 1	
DIALYVITE 800 ORAL TABLET	Tier 1	
DIALYVITE 800 PLUS D	Tier 1	
DIALYVITE 800 WITH ZINC 15	Tier 1	
DIALYVITE 800 WITH ZINC 50	Tier 1	
DIALYVITE 800-ULTRA D	Tier 1	
DIALYVITE SUPREME D	Tier 1	
ESSENTIA	Tier 1	
ESSENTIAL MAN	Tier 1	
ESSENTIAL MAN 50 PLUS	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
ESSENTIAL WOMAN 50 PLUS	Tier 1	
FE C PLUS	Tier 1	AGE (Max 12 Years)
FOLBEE	Tier 1	
FOLBEE PLUS	Tier 1	
FOLBIC	Tier 1	
<i>folic acid oral tablet 1 mg, 800 mcg</i>	Tier 1	
<i>folic acid oral tablet 400 mcg</i>	Tier 1	QL (1 tablet per 1 day)
FOLINIC-PLUS	Tier 1	
FOLPLEX 2.2	Tier 1	
FOLTABS 800	Tier 1	
FREEDAVITE	Tier 1	
FULL SPECTRUM B-VITAMIN C	Tier 1	
HAIR, SKIN AND NAILS-ARGAN OIL	Tier 1	
HAIR,SKIN AND NAILS ORAL TABLET 1 MG IRON-66.7 MCG-1,000 MCG	Tier 1	
HAIR,SKIN AND NAILS(FA-BIOTIN) ORAL TABLET 66.7-1,000 MCG	Tier 1	
HARD NAILS	Tier 1	
HOMOCYSTEINE FORMULA	Tier 1	
ICAPS MV	Tier 1	
IRON 100 PLUS	Tier 1	AGE (Max 12 Years)
KOBEE	Tier 1	
K-PAX IMMUNE SUPPORT	Tier 1	
MEDTYCHOLL-B COMPLEX-LIVER	Tier 1	
MEGA BIOTIN	Tier 1	
MEGA MULTI FOR WOMEN	Tier 1	
MEGA MULTIVITAMIN FOR MEN	Tier 1	
MEN'S DAILY	Tier 1	
MEN'S MULTIVITAMIN GUMMIES ORAL TABLET,CHEWABLE 200 MCG	Tier 1	
MEN'S ONE DAILY	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug Name	Tier	Restrictions/Limits
MERIBIN	Tier 1	
MONOCAPS	Tier 1	
MULTI COMPLETE WITH IRON	Tier 1	
MULTI FOR HER ORAL TABLET	Tier 1	
MULTI-DAY WITH IRON	Tier 1	
<i>multivit-min-iron fum-folic ac</i>	Tier 1	
<i>mv-min-folic acid-lutein</i>	Tier 1	
MYNEPHROCAPS	Tier 1	
NANO VM 1-3	Tier 1	
NANO VM 4-8	Tier 1	
NEPHPLEX RX	Tier 1	
NEPHRON FA	Tier 1	
NESTABS	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
NESTABS DHA	Tier 1	QL (2 capsules per 1 day); AGE (Min 12 Years and Max 55 Years)
NEWGEN	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
<i>niacinamide oral tablet 500 mg</i>	Tier 1	
<i>niacinamide oral tablet extended release</i>	Tier 1	
OMNICAP	Tier 1	
ONE DAILY	Tier 1	
ONE DAILY COMPLETE ORAL TABLET 18-0.4 MG	Tier 1	
ONE DAILY ESSENTIAL ORAL TABLET 0.4 MG, 400 MCG	Tier 1	
ONE DAILY FOR MEN	Tier 1	
ONE DAILY FOR MEN 50 PLUS ADV	Tier 1	
ONE DAILY FOR WOMEN	Tier 1	
ONE DAILY HEALTHY WEIGHT	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.



Drug Name	Tier	Restrictions/Limits
ONE DAILY MAXIMUM	Tier 1	
ONE DAILY MEN'S 50 PLUS MEMORY	Tier 1	
ONE DAILY MULTIVIT-IRON(FOLIC)	Tier 1	
ONE DAILY PLUS IRON	Tier 1	
ONE DAILY WOMEN 50 PLUS	Tier 1	
ONE DAILY WOMENS 50 PLUS	Tier 1	
ONE DAILY WOMEN'S ORAL TABLET 18 MG IRON-400 MCG-450 MG CA	Tier 1	
ONE-A-DAY ENERGY	Tier 1	
ONE-A-DAY MEN VITACRAVES	Tier 1	
ONE-A-DAY MENOPAUSE FORMULA	Tier 1	
ONE-A-DAY MEN'S 50PLUS(GINKGO)	Tier 1	
ONE-A-DAY MEN'S MULTIVITAMIN	Tier 1	
ONE-A-DAY TEEN ADVANTAGE	Tier 1	
ONE-A-DAY VITACRAVES	Tier 1	
ONE-A-DAY VITACRAVES IMMUNITY	Tier 1	
ONE-A-DAY VITACRAVES OMEGA-3	Tier 1	
ONE-A-DAY WEIGHTSMART	Tier 1	
ONE-A-DAY WOMEN VITACRAVES	Tier 1	
ONE-A-DAY WOMEN'S ACTIVE	Tier 1	
ONE-A-DAY WOMEN'S HEALTHY SKIN	Tier 1	
ONE-A-DAY WOMEN'S PETITES	Tier 1	
OPTISOURCE	Tier 1	
OPURITY MULTIVITAMIN	Tier 1	
PARVLEX	Tier 1	
<i>pnv cmb#95-ferrous fumarate-fa</i>	Tier 1	QL (1 tablet per 1 day)
PRENATABS RX	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL COMPLETE	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug Name	Tier	Restrictions/Limits
PRENATAL FORMULA ORAL TABLET 28 MG IRON- 800 MCG	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL MULTI-DHA(WITH VIT K)	Tier 1	AGE (Min 12 Years and Max 55 Years)
PRENATAL MULTIVITAMINS	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL ORAL TABLET 28 MG IRON- 800 MCG	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL PLUS (CALCIUM CARB)	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL TABLET	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL VITAMIN PLUS LOW IRON	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL VITAMIN WITH MINERALS	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PROCERV HP	Tier 1	
PRORENAL	Tier 1	
PRORENAL QD	Tier 1	
PROTECT CARDIO AF	Tier 1	
PROTECT PLUS SO	Tier 1	
QUIN B STRONG	Tier 1	
QUINTABS	Tier 1	
QUINTABS-M	Tier 1	
QUINTABS-M IRON FREE	Tier 1	
RENAL CAPS	Tier 1	
RENA-VITE	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
RENA-VITE RX	Tier 1	
SE-NATAL-19	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
SENTRY	Tier 1	
SENTRY SENIOR	Tier 1	
SIDEROL	Tier 1	
SOLO	Tier 1	
SPECTRAVITE ADVANCED FORMULA	Tier 1	
SPECTRAVITE MEN'S	Tier 1	
STRESS FORMULA WITH IRON	Tier 1	
STRESS FORMULA WITH IRON(SULF)	Tier 1	
SUNVITE	Tier 1	
SUPER MULTIPLE - LOW IRON	Tier 1	
SUPER QUINTS	Tier 1	
SUPER QUINTS B-50	Tier 1	
TAB-A-VITE MULTIVITAMIN W-IRON ORAL TABLET 15 MG IRON- 400 MCG	Tier 1	
THERA	Tier 1	
THERAGRAN-M PREMIER 50 PLUS	Tier 1	
THERALOGIX COMPANION	Tier 1	
THERA-M ORAL TABLET 27-0.4 MG	Tier 1	
THERANATAL ORAL TABLET	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
THERAPEUTIC-M	Tier 1	
TRICARE	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
TRINATAL RX 1	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
TRIPHROCAPS	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug Name	Tier	Restrictions/Limits
ULTRA FREEDA	Tier 1	
V-C FORTE	Tier 1	
VIC-FORTE	Tier 1	
VIRT-CAPS	Tier 1	
VITACEL (WITH LUTEIN)	Tier 1	
VITAL-D RX	Tier 1	
VITALEE	Tier 1	
<i>vitamin b complex oral capsule</i>	Tier 1	
<i>vitamin b complex oral tablet</i>	Tier 1	
<i>vitamin b complex-folic acid</i>	Tier 1	
VITAMINS B COMPLEX	Tier 1	
VITA-RESPA	Tier 1	
VITRUM SENIOR ORAL TABLET 500-300-250 MCG	Tier 1	
WESCAPS	Tier 1	
WESTAB MAX	Tier 1	
WESTAB PLUS	Tier 1	
WOMEN'S MULTIVITAMIN GUMMIES ORAL TABLET,CHEWABLE 200 MCG	Tier 1	
WOMEN'S ONE DAILY ORAL TABLET 18 MG IRON-400 MCG-500 MG CA	Tier 1	
YELETS	Tier 1	
<b>VITAMIN C</b>		
B COMPLEX W-VIT C	Tier 1	
<i>b complex-vitamin c-folic acid</i>	Tier 1	
DECUBI VITE	Tier 1	
DIALYVITE	Tier 1	
DIALYVITE 800 ORAL TABLET	Tier 1	
DIALYVITE 800 PLUS D	Tier 1	
DIALYVITE 800 WITH ZINC 15	Tier 1	
DIALYVITE 800 WITH ZINC 50	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug Name	Tier	Restrictions/Limits
DIALYVITE 800-ULTRA D	Tier 1	
FE C PLUS	Tier 1	AGE (Max 12 Years)
FOLBEE PLUS ORAL TABLET 5 MG	Tier 1	
FULL SPECTRUM B-VITAMIN C	Tier 1	
IRON 100 PLUS	Tier 1	AGE (Max 12 Years)
MYNEPHROCAPS	Tier 1	
NEPHPLEX RX	Tier 1	
NEPHRON FA	Tier 1	
PARVLEX	Tier 1	
PRORENAL	Tier 1	
QUIN B STRONG	Tier 1	
RENAL CAPS	Tier 1	
RENA-VITE	Tier 1	
RENA-VITE RX	Tier 1	
SIDEROL	Tier 1	
STRESS FORMULA WITH IRON	Tier 1	
STRESS FORMULA WITH IRON(SULF)	Tier 1	
TRIPHROCAPS	Tier 1	
TRI-VI-SOL	Tier 1	
TRI-VITAMIN WITH FLUORIDE	Tier 1	QL (2 drops per 1 day); AGE (Max 12 Years)
VIRT-CAPS	Tier 1	
VITAL-D RX	Tier 1	
VITAMINS A,C,D AND FLUORIDE ORAL DROPS 0.25 MG FLUOR. (0.55 MG)/ML	Tier 1	QL (2 ML per 1 day); AGE (Max 12 Years)
WESCAPS	Tier 1	
<b>VITAMIN D</b>		
ACTICAL	Tier 1	
BIOCAL	Tier 1	
<i>calcitriol oral capsule</i>	Tier 1	QL (4 capsules per 1 day)
<i>calcitriol oral solution</i>	Tier 1	AGE (Max 12 Years)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug Name	Tier	Restrictions/Limits
CALCIUM 500 + D ORAL TABLET	Tier 1	
CALCIUM 500 WITH D	Tier 1	
CALCIUM 600 + D(3) ORAL TABLET	Tier 1	
<i>calcium carbonate-vitamin d3 oral tablet 250 mg-3.125 mcg (125 unit), 500 mg-10 mcg (400 unit), 500 mg-15 mcg (600 unit), 500 mg-3.125 mcg (125 unit), 500 mg-5 mcg (200 unit), 600 mg-10 mcg (400 unit), 600 mg-20 mcg (800 unit), 600 mg-5 mcg (200 unit)</i>	Tier 1	
<i>calcium carbonate-vitamin d3 oral tablet, chewable 500 mg-2.5 mcg (100 unit)</i>	Tier 1	
CALCIUM CITRATE + D	Tier 1	
<i>calcium citrate-vitamin d3 oral tablet 315 mg-5 mcg (200 unit), 315 mg-6.25 mcg (250 unit)</i>	Tier 1	
CALCIUM WITH VITAMIN D	Tier 1	
CALTRATE WITH VITAMIN D3	Tier 1	
<i>cholecalciferol (vitamin d3) oral capsule 1,250 mcg (50,000 unit), 10 mcg (400 unit), 125 mcg (5,000 unit), 25 mcg (1,000 unit), 50 mcg (2,000 unit)</i>	Tier 1	
<i>cholecalciferol (vitamin d3) oral drops 10 mcg/ml (400 unit/ml)</i>	Tier 1	
<i>cholecalciferol (vitamin d3) oral tablet 125 mcg (5,000 unit), 25 mcg (1,000 unit), 250 mcg (10,000 unit), 50 mcg (2,000 unit)</i>	Tier 1	
<i>cholecalciferol (vitamin d3) oral tablet, chewable 10 mcg (400 unit)</i>	Tier 1	
CITRACAL + D MAXIMUM	Tier 1	
CITRACAL-D3 MAXIMUM PLUS	Tier 1	
DEKAS ESSENTIAL	Tier 1	
DIALYVITE 800 PLUS D	Tier 1	
DIALYVITE 800-ULTRA D	Tier 1	
DIALYVITE SUPREME D	Tier 1	
DIALYVITE VITAMIN D3 MAX	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug Name	Tier	Restrictions/Limits
DRISDOL	Tier 1	
<i>ergocalciferol (vitamin d2) oral capsule 1,250 mcg (50,000 unit)</i>	Tier 1	
FOSAMAX PLUS D	Tier 3	PA; QL (4 tablets per 28 dayss)
MVW COMPLETE FORMUL MULTIVIT ORAL CAPSULE 750-500 UNIT-MCG	Tier 1	
MVW COMPLETE FORMULATION D3000 ORAL TABLET,CHEWABLE	Tier 1	
OS-CAL 500 + D3	Tier 1	
OYSCO 500/D	Tier 1	
OYSTER SHELL + D3	Tier 1	
OYSTER SHELL CALCIUM-VIT D3	Tier 1	
OYSTERCAL-D	Tier 1	
PRORENAL	Tier 1	
PRORENAL QD	Tier 1	
TRI-VI-SOL	Tier 1	
TRI-VITAMIN WITH FLUORIDE	Tier 1	QL (2 drops per 1 day); AGE (Max 12 Years)
VITAL-D RX	Tier 1	
VITAMIN D2	Tier 1	
VITAMIN D3 ORAL CAPSULE	Tier 1	
VITAMIN D3 ORAL TABLET	Tier 1	
VITAMINS A,C,D AND FLUORIDE ORAL DROPS 0.25 MG FLUOR. (0.55 MG)/ML	Tier 1	QL (2 ML per 1 day); AGE (Max 12 Years)
VITAMINS A-D-E SELENIUM	Tier 1	
<b>VITAMIN E</b>		
DEKAS ESSENTIAL	Tier 1	
STRESS FORMULA WITH IRON	Tier 1	
STRESS FORMULA WITH IRON(SULF)	Tier 1	
<i>vitamin e (dl, acetate) oral capsule 450 mg (1,000 unit), 90 mg (200 unit)</i>	Tier 1	
<i>vitamin e (dl, acetate) oral drops</i>	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we willcover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that iscovered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs firstbefore other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain agerequirement.



Drug Name	Tier	Restrictions/Limits
<i>vitamin e acetate</i>	Tier 1	
<i>vitamin e mixed oral capsule 400 unit</i>	Tier 1	
<i>vitamin e mixed oral tablet</i>	Tier 1	
<i>vitamin e oral capsule 268 mg (400 unit)</i>	Tier 1	
<i>vitamin e oral drops</i>	Tier 1	
<i>vitamin e oral liquid</i>	Tier 1	
<i>vitamin e succinate</i>	Tier 1	
VITAMINS A-D-E SELENIUM	Tier 1	
<i>wheat germ oil</i>	Tier 1	
<b>VITAMIN K ACTIVITY</b>		
A THRU Z SELECT ORAL TABLET 300-60-600-300 MCG	Tier 1	
BIOCAL	Tier 1	
CENTRAL-VITE WOMEN'S MATURE	Tier 1	
CENTRUM CHEWABLES ORAL TABLET,CHEWABLE 8 MG-400 MCG- 10 MCG	Tier 1	
CENTRUM SILVER ULTRA MEN'S	Tier 1	
CENTRUM SILVER WOMEN	Tier 1	
DAILY MULTIVITAMIN	Tier 1	
DEKAS ESSENTIAL	Tier 1	
DEKAS PLUS (FOLIC ACID)	Tier 1	
MEN'S ONE DAILY	Tier 1	
MULTI FOR HER ORAL TABLET	Tier 1	
MVW COMPLETE FORMUL MULTIVIT ORAL CAPSULE 750-500 UNIT-MCG	Tier 1	
MVW COMPLETE FORMULATION D3000 ORAL TABLET,CHEWABLE	Tier 1	
ONE-A-DAY MEN'S MULTIVITAMIN	Tier 1	
OPTISOURCE	Tier 1	
<i>phytonadione (vitamin k1) oral tablet 5 mg</i>	Tier 1	QL (3 tablets per 30 dayss)
PROCERV HP	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we willcover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that iscovered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs firstbefore other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain agerequirement.

<b>Drug Name</b>	<b>Tier</b>	<b>Restrictions/Limits</b>
SOLO	Tier 1	
SUNVITE	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

## Medical Benefit

Drug Name	Tier	Restrictions/Limits
GUARDIAN 4 GLUCOSE SENSOR	Tier 1	
GUARDIAN 4 TRANSMITTER	Tier 1	
GUARDIAN CONNECT TRANSMITTER	Tier 1	
GUARDIAN LINK 3 TRANSMITTER	Tier 1	
GUARDIAN SENSOR 3	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

## Index

24 HOUR NASAL ALLERGY ..... 104, 155	ACULAR LS.....106	AEROCHAMBER PLUS Z STAT SM MSK..... 88
24HR ALLERGY RELIEF 7, 157	ACUVAIL (PF)..... 106	AEROCHAMBER Z-STAT PLUS-FLW SG..... 88
3-DAY VAGINAL..... 164	<i>acyclovir</i> .....16, 17, 163	AEROTRACH PLUS.....88
A THRU Z..... 175	ADACEL(TDAP	AFINITOR DISPERZ..... 20
A THRU Z ADVANCED	ADOLESN/ADULT)(PF)..... 24	AFLURIA QD 2023-24(3YR UP)(PF)..... 24
FORMULA..... 35, 175, 183	<i>adalimumab-adaz</i> ..... 146	AFLURIA QUAD 2023- 2024(6MO UP)..... 24
A THRU Z MEN'S	<i>adalimumab-adbm</i> ..... 146	AFREZZA..... 133, 138
ULTIMATE.....35, 175, 183	ADALIMUMAB-ADB(M)(CF)	AFTERA..... 126
A THRU Z SELECT	PEN CROHNS.....146	AIMOVIG AUTOINJECTOR.. 75
..... 175, 183, 195	ADALIMUMAB-ADB(M)(CF)	AIMSCO LATEX CONDOM.151
A THRU Z SELECT 50PLUS	PEN PS-UV..... 146	AIRDUO DIGIHALER... 30, 121
FORMULA..... 175, 183	<i>adalimumab-fkjp</i> ..... 146	AIRDUO RESPICLICK.. 30, 121
A THRU Z SELECT	<i>adapalene</i> ..... 151, 170	AIRSUPRA..... 30, 121
WOMEN'S..... 35, 175	<i>adapalene-benzoyl peroxide</i> 173	AIRZONE PEAK FLOW METER..... 88
ABC PLUS..... 175, 183	ADBRY..... 169	AJOVY AUTOINJECTOR.....75
<i>abiraterone</i> ..... 20	ADCIRCA..... 64, 159	AJOVY SYRINGE.....75
ABRILADA(CF).....146	<i>adefovir</i> ..... 17	AKEEGA.....20
ABRILADA(CF) PEN..... 146	ADEMPAS..... 66, 159	AKYNZEO (NETUPITANT) ..... 108, 118
ACANYA..... 15, 160, 170	ADIPEX-P.....68	ALAWAY.....100
<i>acarbose</i> .....124	ADLARITY.....29	ALBA-LYBE..... 183
ACCOLATE..... 154	ADMELOG SOLOSTAR U- 100 INSULIN..... 132, 138	<i>albuterol sulfate</i> ..... 30, 158
ACCUPRIL..... 46, 47	ADMELOG U-100 INSULIN	<i>alclometasone</i> ..... 166
ACCURETIC.....46, 47, 65, 98	LISPRO..... 132, 138	<i>alcohol swabs</i> ..... 171
ACE AEROSOL CLOUD	ADTHYZA.....141	<i>alendronate</i> .....149
ENHANCER..... 88	ADULT MULTIVITAMIN	<i>alfuzosin</i> ..... 29
<i>acebutolol</i> ..... 31, 43, 55	GUMMIES..... 175, 183	ALGAL OMEGA-3 DHA..... 118
<i>acetaminophen</i> .....69	ADULT ONE DAILY	ALIMTA.....20
ACETAMINOPHEN EXTRA	GUMMIES..... 175, 183	<i>aliskiren</i> ..... 64
STRENGTH.....69	ADVAIR DISKUS.....30, 121	ALKERAN.....20
ACETAMINOPHEN PAIN	ADVAIR HFA..... 30, 121	ALKINDI SPRINKLE..... 121
RELIEF.....69	ADVANCED ANTACID- ANTIGAS..... 108, 112	ALL DAY ALLERGY (CETIRIZINE)..... 8, 157
<i>acetaminophen-caff- dihydrocod</i> ..... 69, 78, 83	AEMCOLO..... 19	ALL DAY PAIN RELIEF.....83
<i>acetaminophen-codeine</i> .. 69, 78	AEROCHAMBER MINI.....88	ALL DAY RELIEF..... 83
<i>acetazolamide</i> ..... 54, 92, 104	AEROCHAMBER MV.....88	ALLER-CHLOR..... 6, 7, 153
<i>acetic acid</i> .....103	AEROCHAMBER PLUS	ALLER-EASE..... 8, 157
<i>acetylcysteine</i> ..... 151, 155	FLOW-VU..... 88	ALLER-G-TIME..... 5, 6, 153
ACID GONE ANTACID.....108	AEROCHAMBER PLUS	ALLERGY (CHLORPHENIRAMINE) .....6, 7, 153
ACID REDUCER (OMEPRazole)..... 120	FLOW-VU,L MSK..... 88	ALLERGY EYE (NAPHAZOLINE-PHEN).....108
ACIPHEX.....120	AEROCHAMBER PLUS	ALLERGY RELIEF (CETIRIZINE)..... 8, 157
ACIPHEX SPRINKLE..... 120	FLOW-VU,M MSK..... 88	
<i>acitretin</i> ..... 170	AEROCHAMBER PLUS	
ACTEMRA.....144	FLOW-VU,S MSK.....88	
ACTEMRA ACTPEN..... 144	AEROCHAMBER PLUS Z STAT..... 88	
ACTICAL..... 93, 192	AEROCHAMBER PLUS Z	
ACTONEL.....149	STAT LG MSK.....88	
ACTOPLUS MET.....125, 140	AEROCHAMBER PLUS Z	
ACTOS.....140	STAT MD MSK..... 88	
ACULAR..... 106		

ALLERGY RELIEF (FLUTICASONE).....	104, 155	<i>amlodipine-valsartan- hcthiiazid</i>	..... 44, 45, 52, 58, 59, 65, 98	APEXICON E.....	166
ALLERGY RELIEF (LORATADINE).....	8, 157	<i>ammonium lactate</i> .....	165	APIDRA SOLOSTAR U-100	
ALLERGY RELIEF(CHLORPHENIRAM N).....	6, 7, 153	AMNESTEEM.....	170	INSULIN.....	133, 138
ALLERGY RELIEF(DIPHENHYDRAMIN N).....	5, 6, 153	<i>amoxicil-clarithromy- lansopraz</i> .....	11, 17, 120	APIDRA U-100 INSULIN	
ALLERGY-TIME.....	6, 7, 153	<i>amoxicillin</i> .....	11, 114, 119	.....	133, 138
<i>allopurinol</i> .....	148	<i>amoxicillin-pot clavulanate</i>	..... 11, 114, 119	<i>apraclonidine</i> .....	99
ALMACONE-2.....	108, 112	<i>ampicillin</i> .....	11	<i>aprepitant</i> .....	118
<i>almotriptan malate</i> .....	86	AMPYRA.....	151	APRI.....	126
ALOCRIL.....	100, 155	AMRIX.....	27	APRISO.....	113
<i>alogliptin</i> .....	129	<i>anagrelide</i> .....	42	ARANELLE (28).....	127
<i>alogliptin-metformin</i> .....	126, 129	<i>anastrozole</i> .....	20, 125	ARANESP (IN POLYSORBATE).....	33, 34
<i>alogliptin-pioglitazone</i> ..	130, 140	ANCOBON.....	18	<i>arformoterol</i> .....	30, 158
ALOMIDE.....	100	ANDRODERM.....	124	ARICEPT.....	29
ALOPHEN (BISACODYL)...	114	ANDROGEL.....	124	ARIXTRA.....	35
<i>alosetron</i> .....	113	ANORO ELLIPTA	..... 26, 30, 152, 158	ARKALIOX.....	183
ALPHAGAN P.....	99	ANTACID.....	108, 112	ARMONAIR DIGIHALER	
ALREX.....	104	ANTACID (CALCIUM CARBONATE).....	93, 108	.....	121, 155
ALTACE.....	46, 47	ANTACID ANTI-GAS...	109, 112	ARMOUR THYROID.....	141
ALTOPREV.....	60	ANTACID CALCIUM.....	93, 109	ARNUITY ELLIPTA....	122, 156
<i>aluminum hydroxide gel</i> .....	108	ANTACID EXT STR		ARTHROTEC 50.....	77, 119
ALVESCO.....	104, 121, 155	(CALCIUM CARB).....	93, 109	ARTHROTEC 75.....	77, 119
ALYACEN 1/35 (28).....	126	ANTACID EXTRA-		ARTIFICIAL TEARS (PF)....	105
ALYACEN 7/7/7 (28).....	126	STRENGTH.....	93, 109	ARTIFICIAL TEARS	
ALYQ.....	64, 159	ANTACID LIQUID.....	109, 112	(POLYVIN ALC).....	105
<i>amantadine hcl</i> .....	10, 27, 68	ANTACID M.....	109, 112	ARTIFICIAL TEARS(DEXT70-HYPRO)...	105
<i>ambrisentan</i> .....	66, 159	ANTACID MAXIMUM		ARTIFICIAL TEARS(GLYCERIN-PEG)...	106
<i>amiloride</i> .....	64, 93	STRENGTH.....	109, 112	ARTIFICIAL TEARS(PVALCH-POVID)...	106
<i>amiloride- hydrochlorothiazide</i>	..... 64, 65, 93, 98	ANTACID PLUS ANTI-GAS		ASCOMP WITH CODEINE	
<i>amiodarone</i> .....	56	.....	109, 112	.....	72, 74, 78, 83, 85
AMITIZA.....	117	ANTACID REGULAR		ASMANEX HFA.....	122, 156
AMJEVITA(CF).....	146	STRENGTH.....	109, 112	ASMANEX TWISTHALER	
AMJEVITA(CF)		ANTACID ULTRA		.....	122, 156
AUTOINJECTOR.....	146	STRENGTH.....	93, 109	ASPERCREME	
<i>amlodipine</i> .....	52, 58, 61, 66	ANTACID-ANTIGAS...	109, 112	(LIDOCAINE HCL).....	163
<i>amlodipine-atorvastatin</i>	..... 52, 58, 59, 60, 66	ANTI-DIARRHEAL.....	109, 111	ASPERCREME	
<i>amlodipine-benazepril</i>	..... 46, 47, 52, 58, 59, 61, 66	ANTI-DIARRHEAL		(LIDOCAINE).....	163
<i>amlodipine-olmesartan</i>	..... 43, 45, 52, 58, 59, 61, 66	(LOPERAMIDE).....	111	<i>aspirin</i> .....	41, 42, 72, 85
<i>amlodipine-valsartan</i>	..... 44, 45, 52, 58, 59, 61, 66	ANTIFUNGAL		ASPIRIN CHILDRENS	
		(CLOTRIMAZOLE).....	164	.....	40, 42, 72, 85
		ANTIFUNGAL		<i>aspirin,buffd-calcium carb- mag</i> .....	41, 42, 72, 85
		(MICONAZOLE).....	164	<i>aspirin-dipyridamole</i> ..	41, 85, 91
		ANTIFUNGAL		ASTHMA CHECK METER....	88
		(TOLNAFTATE).....	174	ATACAND.....	44, 45
		ANTI-ITCH (HC).....	166	ATACAND HCT ...	44, 45, 65, 98
		APETEX.....	183	ATELVIA.....	149
		APETIGEN.....	183	<i>atenolol</i> .....	31, 43, 55

<i>atenolol-chlorthalidone</i>	BALANCED B-100.....184	<i>benazepril-</i>
.....32, 49, 50, 55, 66, 99	BALANCED B-100	<i>hydrochlorothiazide</i>
ATHENOL.....69	COMPLEX.....184	.....46, 47, 65, 98
ATORVALIQ.....60	BALANCED B-50.....184	BENICAR.....44, 45
<i>atorvastatin</i> .....60	<i>balsalazide</i> .....113	BENICAR HCT ... 44, 45, 65, 98
<i>atovaquone</i> .....12	BANOPHEN.....5, 6, 153	<i>benznidazole</i> .....16
<i>atropine</i> .....107	BAQSIMI.....5, 131	<i>benzoyl peroxide</i> .....170
ATROVENT HFA.....26, 152	BASAGLAR KWIKPEN U-	<i>benzphetamine</i> .....68
AUBAGIO.....142	100 INSULIN.....133, 135	<i>bepotastine besilate</i> .....100
AURYXIA.....92	BASAGLAR TEMPO	BEPREVE.....100
AUSTEDO.....87	PEN(U-100)INSLN.....133, 135	BESER.....166
AUSTEDO XR.....87	BAXDELA.....18	BESER KIT.....166
AUVI-Q.....25, 152	BAYER ASPIRIN.41, 42, 72, 86	BESIVANCE.....101
AVALIDE.....44, 45, 65, 98	BAYER CHEWABLE	BESREMI.....20
AVAPRO.....44, 45	ASPIRIN.....41, 42, 72, 86	<i>beta carotene</i> .....182
AVIANE.....127	BAYER LOW DOSE	<i>betamethasone dipropionate</i>
AVODART.....148	ASPIRIN.....41, 42, 72, 86	.....166
AVONEX.....143	B-COMPLEX WITH B-12.....184	<i>betamethasone valerate</i> .....166
AZASITE.....100	B-COMPLEX WITH	<i>betamethasone, augmented</i> 166
<i>azathioprine</i> .....142	VITAMIN C.....184	BETAPACE
<i>azelastine</i> .....100	BD ALCOHOL SWABS.....171	.....28, 49, 51, 55, 57, 61
<i>azelastine-fluticasone</i>	BD AUTOSHIELD DUO	BETAPACE AF
.....100, 104, 155, 157	PEN NEEDLE.....88	.....28, 49, 50, 55, 57, 61
AZILECT.....77	BD INSULIN SYRINGE	BETASERON.....144
<i>azithromycin</i> .....17	(HALF UNIT).....89	BETATEMP.....69
AZOPT.....104	BD INSULIN SYRINGE U-	<i>betaxolol</i> .....32, 50, 55, 103
AZOR.44, 45, 52, 58, 59, 61, 67	500.....89	<i>bethanechol chloride</i> .....29
AZULFIDINE.....19, 113, 143	BD INSULIN SYRINGE	BETHKIS.....10
AZULFIDINE EN-TABS	ULTRA-FINE.....89	BETIMOL.....103
.....19, 113, 143	BD NANO 2ND GEN PEN	BETOPTIC S.....103
AZURETTE (28).....127	NEEDLE.....89	BEVESPI AEROSPHERE
B COMPLEX.....183	BD ULTRA-FINE MICRO	.....26, 30, 152, 158, 164
B COMPLEX 1 (WITH	PEN NEEDLE.....89	<i>bexarotene</i> .....20, 163
FOLIC ACID).....183	BD ULTRA-FINE MINI PEN	BEXSERO.....24
B COMPLEX 100.....183	NEEDLE.....89	BEYFORTUS.....16
B COMPLEX PLUS	BD ULTRA-FINE NANO	<i>bicalutamide</i> .....20
VITAMIN C.....183	PEN NEEDLE.....89	<i>bimatoprost</i> .....107
B COMPLEX W-VIT C.183, 191	BD ULTRA-FINE ORIG PEN	BIMZELX.....169
<i>b complex-vitamin c-folic</i>	NEEDLE.....89	BIMZELX AUTOINJECTOR 169
<i>acid</i> .....183, 191	BD ULTRA-FINE SHORT	BIO-35, GLUTEN FREE
B-100 COMPLEX.....183	PEN NEEDLE.....89	.....35, 93, 175, 184
BABY AYR SALINE.....106	BD VEO INSULIN SYR	BIOCAL.....93, 184, 192, 195
<i>bacitracin</i> .....100, 161	(HALF UNIT).....89	BIOCEL (WITH LUTEIN)
<i>bacitracin zinc</i> .....161	BD VEO INSULIN SYRINGE	.....175, 184
<i>bacitracin-polymyxin b</i> .....100	UF.....89	BION TEARS (PF).....106
<i>baclofen</i> .....28	BEELITH.....93, 184	BIOPETIT.....184
BACMIN.....35, 175, 183	BELBUCA.....82	<i>biotin</i> .....184
BAFIERTAM.....143	<i>benazepril</i> .....46, 47	<i>bisacodyl</i> .....114
BALANCE B-100 (FOLIC		BISMUTH.....109, 111
ACID).....183		<i>bismuth subcit k-metronidz-</i>
BALANCE B-50 (WITH		<i>tcn</i> .....10, 11, 12, 18, 19, 113
FOLIC ACID).....183		<i>bismuth subsalicylate</i> .. 109, 111



<i>bisoprolol fumarate</i> .....	32, 50, 55	BYSTOLIC.....	28, 50	<i>carvedilol phosphate</i>	
<i>bisoprolol-</i>		<i>cabergoline</i> .....	77	.....	28, 29, 43, 56, 65
<i>hydrochlorothiazide</i>		CADUET.....	52, 58, 59, 60, 67	CAYA CONTOURED.....	151
.....	32, 50, 51, 56, 65, 98	<i>caffeine citrate</i> .....	83	CAYSTON.....	15
BLINCYTO.....	20	<i>calcipotriene</i> .....	165	CAZANT (28).....	127
BLISOVI 24 FE.....	127	<i>calcitonin (salmon)</i> .....	125, 149	<i>cefaclor</i> .....	9
BLISOVI FE 1.5/30 (28).....	127	<i>calcitriol</i> .....	173, 192	<i>cefadroxil</i> .....	9
BLISOVI FE 1/20 (28).....	127	CALCIUM 500 + D.....	93, 193	<i>cefdinir</i> .....	9
BODY, HAIR, SKIN AND		CALCIUM 500 WITH D..	93, 193	<i>cefixime</i> .....	9
NAILS.....	175	CALCIUM 600.....	93	<i>cefpodoxime</i> .....	10
<i>bosentan</i> .....	67, 159	CALCIUM 600 + D(3)....	93, 193	<i>cefprozil</i> .....	9
BRAFTOVI.....	20	<i>calcium acetate(phosphat</i>		<i>cefuroxime axetil</i> .....	9
BREATHERITE MDI		<i>bind)</i> .....	92	CELEBREX.....	76
SPACER.....	89	CALCIUM ANTACID.....	93, 109	<i>celecoxib</i> .....	76
BREATHERITE VALVED		<i>calcium carbonate</i> ...	93, 94, 109	CENTANY.....	161
MDI CHAMBER.....	89	<i>calcium carbonate-vitamin</i>		CENTANY AT.....	161
BREATHERITE VALVED		<i>d3</i> .....	94, 193	CENTRAL-VITE WOMEN'S	
MDI SPACER.....	89	<i>calcium citrate</i> .....	94	MATURE.....	35, 175, 184, 195
BREO ELLIPTA.....	30, 122	CALCIUM CITRATE + D94,	193	CENTRAVITES.....	175
BREXAFEMME.....	20	<i>calcium citrate-vitamin d3</i>		CENTRUM CHEWABLES	
BREYNA.....	30, 122	.....	94, 193	.....	35, 175, 184, 195
BREZTRI AEROSPHERE		CALCIUM WITH VITAMIN D		CENTRUM COMPLETE	
.....	152, 156, 158	.....	94, 193	.....	35, 175, 184
BRIELLYN.....	127	CAL-GEST ANTACID....	94, 109	CENTRUM MEN....	36, 175, 184
BRILINTA.....	41	CALTRATE WITH VITAMIN		CENTRUM SILVER....	175, 184
<i>brimonidine</i> .....	99	D3.....	94, 193	CENTRUM SILVER ULTRA	
<i>brimonidine-timolol</i> .....	99, 103	CAMCEVI (6 MONTH)....	21, 132	MEN'S.....	175, 184, 195
<i>brinzolamide</i> .....	104	CAMILA.....	127	CENTRUM SILVER	
<i>bromfenac</i> .....	106	<i>candesartan</i> .....	44, 45	WOMEN.....	36, 175, 184, 195
<i>bromocriptine</i> .....	77	<i>candesartan-</i>		CENTRUM SPECIALIST	
BROMSITE.....	106	<i>hydrochlorothiazid</i> 44,	45, 65, 98	HEART.....	176
BRONCHITOL.....	157	<i>capecitabine</i> .....	21	CENTRUM ULTRA MEN'S	
BROVANA.....	30, 159	<i>captopril</i> .....	46, 47	.....	36, 176, 184
BRYHALI.....	166	<i>captopril-hydrochlorothiazide</i>		CENTURY.....	36, 176, 184
<i>budesonide</i> ..	104, 122, 155, 156	.....	46, 47, 65, 98	CENTURY MATURE...	176, 184
<i>budesonide-formoterol</i> ...	30, 122	<i>carbidopa</i> .....	76	<i>cephalexin</i> .....	9
BUFFERIN.....	41, 42, 72, 86	<i>carbidopa-levodopa</i> .....	76	CEQUA.....	103, 142
<i>buprenorphine</i> .....	82	<i>carbidopa-levodopa-</i>		CERALYTE-70.....	94
<i>bupropion hcl (smoking</i>		<i>entacapone</i> .....	75, 76	CERTA PLUS.....	36, 176, 184
<i>deter)</i> .....	72	<i>carbinoxamine maleate</i> ...	6, 153	CERTAVITE SENIOR..	176, 184
<i>butalbital-acetaminop-caf-</i>		<i>carboxymethylcellulose</i>		CERTAVITE-ANTIOXIDANT	
<i>cod</i> .....	69, 72, 74, 78, 83	<i>sodium</i> .....	106	.....	36, 176, 184
<i>butalbital-acetaminophen</i>	69, 74	CARDIZEM.....	52, 57	<i>cetirizine</i> .....	8, 157, 158
<i>butalbital-acetaminophen-</i>		CARDIZEM CD.....	52, 57	CHANTIX CONTINUING	
<i>caff</i> .....	69, 72, 74, 83	CARDIZEM LA.....	52, 57	MONTH BOX.....	32
<i>butalbital-aspirin-caffeine</i>		CARDURA.....	29, 43, 61	CHEMET.....	5, 121
.....	41, 42, 73, 74, 83, 86	CARDURA XL.....	29, 43, 61	CHILD ALLERGY	
<i>butenafine</i> .....	166	<i>carteolol</i> .....	103	REL(CETIRIZINE).....	8, 158
<i>butorphanol</i> .....	82	CARTIA XT.....	52, 57	CHILD FEVER REDUCER-	
BUTRANS.....	82	<i>carvedilol</i> .....	28, 29, 43, 56, 65	PAIN RELVR.....	69
BYDUREON BCISE.....	132			CHILD PAIN REL-FEVER	
BYETTA.....	132			REDUCER.....	69



CHILDREN'S	<i>cinacalcet</i> .....	125	<i>colestipol</i> .....	52
ACETAMINOPHEN.....	CIPRO.....	12, 18, 101	COMBIGAN.....	99, 103
CHILDREN'S ALAWAY.....	CIPRO HC.....	12, 18, 101, 104	COMBIVENT RESPIMAT	
CHILDREN'S ALLERGY	<i>ciprofloxacin</i> .....	12, 18, 101	.....	26, 30, 152, 159
RELIEF(FEX).....	<i>ciprofloxacin hcl</i> .....	12, 19, 101	COMFORT GEL.....	109, 112
CHILDREN'S ALLERGY	<i>ciprofloxacin-</i>		COMFORT GEL EXTRA	
RELIEF(LOR).....	<i>dexamethasone</i> .....	19, 101, 105	STRENGTH.....	109, 112
CHILDREN'S	<i>ciprofloxacin-fluocinolone</i>		COMPLETE	
ALLERGY(CETIRIZINE)..	.....	19, 101, 105	MULTIVITAMIN-MINERAL	
CHILDREN'S ASPIRIN	CITRACAL + D MAXIMUM		.....	36, 176, 185
.....	.....	94, 193	COMPLETE MV ADULT 50	
CHILDREN'S CETIRIZINE	CITRACAL-D3 MAXIMUM		PLUS.....	176, 185
.....	PLUS.....	94, 193	COMPLETENATE. 36, 176, 185	
CHILDREN'S FEVER	CITRATE OF MAGNESIA... 114		COMPLEX B-100.....	185
REDUCING.....	CITROMA.....	114	COMPLEX B-50.....	185
CHILDREN'S FLONASE	CLARAVIS.....	171	CONZIP.....	78
ALLERGY RLF.....	CLARINEX.....	8, 158	COPAXONE.....	142
CHILDREN'S IBUPROFEN... 83	<i>clarithromycin</i> .....	12, 13, 17	COREG.....	28, 29, 43, 56, 65
CHILDREN'S LORATADINE	CLASSIC PRENATAL		COREG CR... 28, 30, 43, 56, 65	
.....	.....	36, 176, 184	CORGARD.....	50, 51, 56
CHILDREN'S MAPAP.....	CLEOCIN.....	15, 161	CORLANOR.....	54
CHILDREN'S NON-ASPIRIN.70	<i>clindamycin hcl</i> .....	15, 161	CORRECTOL.....	114
CHILDREN'S PAIN RELIEF.. 70	CLINDAMYCIN PEDIATRIC		CORVITE FREE.....	176, 185
CHILDREN'S PAIN-FEVER	.....	15, 161	COSENTYX.....	144
RELIEF.....	<i>clindamycin phosphate</i> .. 15, 161		COSENTYX (2 SYRINGES) 144	
CHILDREN'S TYLENOL..... 70	<i>clindamycin-benzoyl</i>		COSENTYX PEN.....	144
CHILD'S ALL DAY	<i>peroxide</i> .....	15, 161, 171	COSENTYX PEN (2 PENS) 144	
ALLERGY(CETIR).....	CLINDESSE.....	15, 161	COSENTYX UNOREADY	
<i>chlorhexidine gluconate</i> ..... 103	<i>clobetasol</i> .....	166	PEN.....	144
<i>chloroquine phosphate</i> ..... 11	<i>clobetasol-emollient</i> ..... 167		COSOFT.....	103, 104
<i>chlorpheniramine maleate</i>	CLOBEX.....	167	COSOFT (PF).....	103, 104
.....	<i>clocortolone pivalate</i> ..... 167		COZAAR.....	44, 45
.....	CLODAN.....	167	CREAMY ACNE FACE.....	171
CHLORTABS.....	CLODAN KIT.....	167	CREON.....	117
<i>chlorthalidone</i> .....	<i>clonidine</i> .....	26, 54	CRESEMBA.....	13
.....	<i>clonidine hcl</i> .....	26, 54	CRINONE.....	137
.....	<i>clopidogrel</i> .....	41	<i>cromolyn</i> .....	100, 155
.....	<i>clotrimazole</i> .....	164	CRYSSELLE (28).....	127
.....	CLOTTRIMAZOLE 3 DAY.... 164		CULTURELLE.....	118
.....	CLOTTRIMAZOLE-3.....	164	<i>cyanocobalamin (vitamin b-</i>	
.....	CLOTTRIMAZOLE-7.....	164	<i>12)</i> .....	185
.....	<i>clotrimazole-betamethasone</i>		<i>cyclobenzaprine</i> .....	27
.....	.....	164, 167	<i>cyclopentolate</i> .....	107
.....	<i>codeine sulfate</i> .....	78, 153	<i>cyclophosphamide</i> .....	21, 143
.....	<i>codeine-butalbital-asa-caff</i>		<i>cycloserine</i> .....	13
.....	.....	73, 74, 78, 83, 86	<i>cyclosporine</i> .....	103, 142
.....	COLACE CLEAR.....	114	<i>cyclosporine modified</i> .....	142
.....	COLAZAL.....	113	CYLTEZO(CF).....	146
.....	<i>colchicine</i> .....	54, 148	CYLTEZO(CF) PEN.....	146
.....	COLCRYS.....	54, 148	CYLTEZO(CF) PEN	
.....	<i>colesevelam</i> .....	51, 125	CROHN'S-UC-HS.....	146
.....	COLESTID.....	51, 52		

CYLTEZO(CF) PEN	DERMA-SMOOTH/FS	DIFICID.....17
PSORIASIS-UV.....146	BODY OIL.....167	<i>diflorasone</i> .....167
<i>cyproheptadine</i> .....6, 153	DERMA-SMOOTH/FS	DIFLUCAN.....13
CYTOMEL.....141	SCALP OIL.....167	<i>diflunisal</i> .....83
<i>dabigatran etexilate</i> .....34	<i>desloratadine</i> .....8, 9, 158	<i>digoxin</i> .....54
DAILY FIBER (PSYLLIUM-SUCROSE).....114	<i>desmopressin</i> .....35, 136	DILAUDID.....78, 79
DAILY GUMMIES.....176, 185	<i>desog-e.estradiol/e.estradiol</i> 127	<i>diltiazem hcl</i> .....52, 53, 57
DAILY MULTIPLE FOR WOMEN.....36, 94, 176, 185	<i>desogestrel-ethinyl estradiol</i> 127	DILT-XR.....53, 57
DAILY MULTIVITAMIN.....176, 185, 195	<i>desonide</i> .....167	<i>dimenhydrinate</i> ....5, 6, 113, 153
DAILY MULTIVITAMIN WITH IRON.....36, 176, 185	DESOWEN.....167	<i>dimethyl fumarate</i> .....143
DAILY VALUE.....176	<i>desoximetasone</i> .....167	DIOTAME.....109, 111
DAILY VITAMIN FORMULA	DETROL.....174	DIOVAN.....44, 45
DAILY VITAMIN FORMULA-IRON.....36, 176, 185	DETROL LA.....174	DIOVAN HCT.....44, 45, 65, 98
DAILY VITAMIN FORMULA-MINERALS.....176	<i>dexamethasone</i> .....122	DIPENTUM.....113
DAILY VITAMIN WITH IRON.....36, 176	<i>dexamethasone sodium phos (pf)</i> .....122	<i>diphenhydramine hcl</i> ...6, 7, 154
DAILY VITES/IRON.....36, 176	<i>dexamethasone sodium phosphate</i> .....105, 122	<i>diphenoxylate-atropine</i> ..26, 111
DAILY-VITE.....176	DEXILANT.....120	DIPROLENE (AUGMENTED).....167
DAILY-VITE (WITH FOLIC ACID).....176, 185	<i>dexlansoprazole</i> .....120	<i>dipyridamole</i> .....41, 91
<i>dalfampridine</i> .....151	DHIVY.....76	DISKETS.....79
DALIRESP.....156, 170	DIABETES HEALTH FORMULA.....177, 185	<i>disopyramide phosphate</i> .....55
<i>danazol</i> .....124	DIALYVITE.....185, 191	DIURIL.....65, 98
DANTRIUM.....27	DIALYVITE 3000.....185	<i>docosanol</i> .....163
<i>dantrolene</i> .....28	DIALYVITE 5000.....185	DOCUPRENE.....114
<i>dapaglifloz propaned-metformin</i> .....126, 139	DIALYVITE 800.....185, 191	<i>docusate calcium</i> .....114
<i>dapagliflozin propanediol</i> ....139	DIALYVITE 800 PLUS D.....185, 191, 193	<i>docusate sodium</i> .....114
<i>dapsone</i> .....11	DIALYVITE 800 WITH ZINC 15.....185, 191	DOK.....114
<i>darifenacin</i> .....174	DIALYVITE 800 WITH ZINC 50.....185, 191	<i>donepezil</i> .....29
DASETTA 1/35 (28).....127	DIALYVITE 800-ULTRA D.....185, 192, 193	<i>dorzolamide</i> .....104
DASETTA 7/7/7 (28).....127	DIALYVITE SUPREME D.....185, 193	<i>dorzolamide-timolol</i> ....103, 104
DAURISMO.....21	DIALYVITE VITAMIN D3 MAX.....193	<i>dorzolamide-timolol (pf)</i> .....103, 104
DAYHIST ALLERGY...5, 6, 153	DIARRHEA RELIEF (BISMUTH SUBS).....109, 111	<i>doxazosin</i> .....29, 43, 62
DAYPRO.....83	<i>diazoxide</i> .....125	<i>doxycycline hyclate</i> .....11, 19, 20, 101, 161
DEBLITANE.....127	<i>diclofenac epolamine</i> ....78, 172	<i>doxycycline monohydrate</i> .....11, 12, 20, 101, 161
DECUBI VITE.....176, 185, 191	<i>diclofenac potassium</i> .....73, 83, 172	DRISDOL.....194
DEKAS ESSENTIAL.....176, 183, 193, 194, 195	<i>diclofenac sodium</i> .....21, 73, 78, 83, 106, 172	<i>dronabinol</i> .....118
DEKAS PLUS (FOLIC ACID).....176, 185, 195	<i>diclofenac-misoprostol</i> ...78, 119	<i>drospirenone-ethinyl estradiol</i> .....127
DEKAS PLUS LIQUID.....177	<i>dicloxacillin</i> .....18	DROXIA.....21
DELESTROGEN.....130	<i>dicyclomine</i> .....26	DUAKLIR PRESSAIR.....26, 30, 153, 159
DELZICOL.....113	<i>diethylpropion</i> .....68	DUAL ACTION PAIN RELIEVER.....70, 78
DENAVIR.....163	DIFFERIN.....151, 171	DUETACT.....140, 141
DENTA 5000 PLUS.....88		DUEXIS.....78, 118
		DULCOLAX (BISACODYL).115
		DULERA.....31, 122
		DUOPA.....76
		DUPIXENT PEN.....173

DUPIXENT SYRINGE.....	173	ENGERIX-B PEDIATRIC	<i>ethynodiol diac-eth estradiol</i>	127
<i>dutasteride</i> .....	148	(PF).....	<i>etodolac</i> .....	83
<i>dutasteride-tamsulosin</i> ..	30, 148	<i>enoxaparin</i> .....	<i>etonogestrel-ethinyl estradiol</i>	
DYMISTA.....	100, 105, 155, 158	ENPRESSE.....	.....	127
E.E.S. 400.....	14, 101, 161	ENSKYCE.....	<i>etoposide</i> .....	21
E.E.S. GRANULES	14, 101, 161	ENSPRYNG.....	EUCRISA.....	172
EASIVENT HOLDING		<i>entacapone</i> .....	<i>everolimus (antineoplastic)</i> ....	21
CHAMBER.....	89	ENTADFI.....	<i>everolimus</i>	
EASIVENT MASK LARGE ...	89	<i>entecavir</i> .....	<i>(immunosuppressive)</i> .....	151
EASIVENT MASK MEDIUM..	89	ENTRESTO.....	EVISTA.....	130, 149
EASIVENT MASK SMALL....	89	ENTYVIO.....	EXELON PATCH.....	29
EASY TOUCH ALCOHOL		ENTYVIO PEN.....	<i>exemestane</i> .....	21, 125
PREP PADS.....	171	EPANED.....	EXFORGE	
EC-NAPROXEN.....	83	<i>epinastine</i> .....	.....	44, 45, 53, 58, 59, 62, 67
<i>econazole</i> .....	164	<i>epinephrine</i> .....	EXFORGE HCT	
ECONTRA EZ.....	127	EPIPEN.....	.....	44, 45, 53, 58, 59, 65, 98
ECOTRIN LOW STRENGTH		EPIPEN 2-PAK.....	EX-LAX (SENNOSIDES).....	115
.....	41, 42, 73, 86	EPIPEN JR.....	EX-LAX MAXIMUM	
EDARBI.....	44, 45	EPIPEN JR 2-PAK.....	STRENGTH.....	115
EDARBYCLOR....	44, 45, 66, 99	EPOGEN.....	EXSERVAN.....	68
EFFIENT.....	41	<i>eprosartan</i> .....	EXTINA.....	13, 164
<i>electrolytes-dextrose</i> .....	94	<i>ergocalciferol (vitamin d2)</i> ...	EYE ALLERGY RELIEF.....	108
<i>eletriptan</i> .....	86	ERIVEDGE.....	EYE HEALTH PLUS	
ELIDEL.....	169	ERLEADA.....	LUTEIN.....	177
ELINEST.....	127	ERMEZA.....	EYE ITCH RELIEF.....	100
ELIQUIS.....	33	ERRIN.....	EYSUVIS.....	105
ELIQUIS DVT-PE TREAT		ERTACZO.....	EZALLOR SPRINKLE.....	60
30D START.....	33	ERYPED 200.....	<i>ezetimibe</i> .....	55
ELLA.....	127	ERYPED 400.....	<i>ezetimibe-simvastatin</i> .....	55, 61
ELMIRON.....	5	ERY-TAB.....	FALMINA (28).....	127
ELURYNG.....	127	ERYTHROCIN (AS	<i>famciclovir</i> .....	17
ELYXYB.....	76	STEARATE).....	<i>famotidine</i> .....	118
EMCYT.....	21	<i>erythromycin</i> .....	FANTASY CONDOM.....	151
EMEND.....	119	<i>erythromycin ethylsuccinate</i>	FARXIGA.....	139
EMFLAZA.....	122	.....	FASENRA PEN.....	154
EMGALITY PEN.....	75	<i>erythromycin with ethanol</i> ....	FASTEP COVID-19 AG	
EMGALITY SYRINGE.....	75	<i>erythromycin-benzoyl</i>	HOME TEST.....	89
<i>enalapril maleate</i> .....	46, 47	<i>peroxide</i> .....	FC2 FEMALE CONDOM.....	151
<i>enalapril-hydrochlorothiazide</i>		ESGIC.....	FE C PLUS.....	36, 186, 192
.....	46, 47, 65, 98	<i>esomeprazole magnesium</i> ..	<i>febuxostat</i> .....	148
ENBREL.....	146	ESSENTIA.....	FELDENE.....	84
ENBREL MINI.....	146	.....	<i>felodipine</i> .....	53, 58, 59, 62, 67
ENBREL SURECLICK.....	146	ESSENTIAL MAN.....	FEMCAP.....	89, 151
ENDARI.....	173	.....	<i>fenofibrate</i> .....	60
ENDOCET.....	70, 79	ESSENTIAL MAN 50 PLUS	<i>fenofibrate micronized</i> .....	60
ENDUR-ACIN.....	48	.....	<i>fenofibrate nanocrystallized</i> ..	60
ENEMA.....	115	PLUS.....	<i>fenofibric acid</i> .....	60
ENEMA DISPOSABLE.....	115	ESTARYLLA.....	<i>fenofibric acid (choline)</i> .....	60
ENEMEEZ PLUS.....	115	<i>estradiol</i> .....	FENOGLIDE.....	60
ENFAMIL ENFALYTE.....	94	<i>estradiol valerate</i> .....	<i>fenoprofen</i> .....	84
ENGERIX-B (PF).....	24	<i>estradiol-norethindrone acet</i>	<i>fentanyl</i> .....	79
		.....	<i>fentanyl citrate</i> .....	79
		<i>ethambutol</i> .....		
		.....		
		131, 137		
		13		

FENTORA.....	79	FLULAVAL QUAD 2023-2024 (PF).....	25	FREESTYLE CONTROL.....	89
FEOSOL.....	36	FLUMADINE.....	10	FREESTYLE FREEDOM.....	89
FERATE.....	36	FLUMIST QUAD 2023-2024..	25	FREESTYLE FREEDOM LITE.....	89
FERGON.....	36	<i>flunisolide</i> .....	105, 155	FREESTYLE INSULINX.....	89
FEROSUL.....	36	<i>fluocinolone</i> .....	167	FREESTYLE INSULINX TEST STRIPS.....	91
FERRO-TIME.....	36	<i>fluocinolone and shower cap</i> .....	167	FREESTYLE LANCETS.....	89
<i>ferrous gluconate</i> .....	36	<i>fluocinonide</i> .....	167	FREESTYLE LITE METER...	89
<i>ferrous sulfate</i> .....	36, 37	FLUOCINONIDE-E.....	167	FREESTYLE LITE STRIPS...	91
<i>fesoterodine</i> .....	174	<i>fluocinonide-emollient</i> .....	167	FREESTYLE PRECISION NEO METER.....	89
FEVER REDUCER.....	70	<i>fluoride (sodium)</i> .....	88	FREESTYLE PRECISION NEO STRIPS.....	91
FEVERALL.....	70	<i>fluorometholone</i> .....	105	FREESTYLE TEST.....	91
FEXMID.....	27	<i>fluorouracil</i> .....	21, 163	FROVA.....	86
<i>fexofenadine</i> .....	9, 158	<i>flurandrenolide</i> .....	167	<i>frovatriptan</i> .....	86
FIASP FLEXTOUCH U-100 INSULIN.....	133, 138	<i>flurbiprofen</i> .....	84	FULL SPECTRUM B-VITAMIN C.....	186, 192
FIASP PENFILL U-100 INSULIN.....	133, 138	<i>flurbiprofen sodium</i> .....	106	FULPHILA.....	34
FIASP PUMPCART....	133, 138	<i>fluticasone furoate-vilanterol</i> .....	31, 123	<i>furosemide</i> .....	62, 92
FIASP U-100 INSULIN	133, 138	<i>fluticasone propionate</i> .....	105, 123, 155, 156, 167	FYLNETRA.....	34
FIBER (PSYLLIUM HUSK-SUGAR).....	115	<i>fluticasone propion-salmeterol</i> .....	31, 123	<i>gabapentin</i> .....	70
FIBER (WITH ASPARTAME).....	115	<i>fluvastatin</i> .....	61	<i>galantamine</i> .....	29
<i>finasteride</i> .....	148, 166	FLUZONE HIGHDOSE QUAD 23-24 PF.....	25	GARDASIL 9 (PF).....	25
<i> fingolimod</i> .....	145	FLUZONE QUAD 2023-2024.....	25	GAS RELIEF (SIMETHICONE).....	112
FIORICET WITH CODEINE.....	70, 73, 74, 79, 83	FLUZONE QUAD 2023-2024 (PF).....	25	GAS RELIEF 80 (SIMETHICONE).....	112
FIRVANQ.....	15	FOAMING ANTACID.....	109	GAS RELIEF EXTRA STRENGTH.....	112
FISH OIL.....	48, 49	FOLBEE.....	186	GAS-X EXTRA STRENGTH	112
FLAGYL...	10, 16, 114, 162, 173	FOLBEE PLUS.....	186, 192	<i>gatifloxacin</i> .....	102
FLAVOR CHEWS ANTACID.....	94, 109	FOLBIC.....	186	GAVISCON.....	109
<i>flavoxate</i> .....	174	<i>folic acid</i> .....	186	GELNIQUE.....	174
<i>flecainide</i> .....	55	FOLINIC-PLUS.....	186	<i>gemfibrozil</i> .....	60
FLECTOR.....	78, 172	FOLPLEX 2.2.....	186	GEMTESA.....	175
FLEET ENEMA.....	115	FOLTABS 800.....	186	GENOTROPIN.....	136
FLEET MINERAL OIL.....	115	<i>fondaparinux</i> .....	35	GENOTROPIN MINIQUICK	136
FLEQSUVY.....	28	<i>formoterol fumarate</i> .....	31, 159	<i>gentamicin</i> .....	102, 162
FLOMAX.....	30	FORTAVIT.....	37, 177	GENTLE LAXATIVE (BISACODYL).....	115
FLUAD QUAD 2023-24(65Y UP)(PF).....	24	FORTEO.....	136, 149	GERI-KOT.....	115
FLUARIX QUAD 2023-2024 (PF).....	24	FORTESTA.....	124	GERI-LANTA.....	109, 112
FLUBLOK QUAD 2023-2024 (PF).....	24	FOSAMAX.....	149	GERI-MOX ANTACID-ANTIGAS.....	109, 112
FLUCELVAX QUAD 2023-2024.....	24	FOSAMAX PLUS D....	149, 194	GERI-MUCIL (ASPARTAME).....	115
FLUCELVAX QUAD 2023-2024 (PF).....	24	<i>fosinopril</i> .....	46, 47	GILENYA.....	145
<i>fluconazole</i> .....	13	<i>fosinopril-hydrochlorothiazide</i> .....	46, 48, 65, 98	<i>glatiramer</i> .....	142
<i>flucytosine</i> .....	18	FOSRENOL.....	92	GLATOPA.....	142
<i>fludrocortisone</i> .....	123	FRAGMIN.....	35	<i>glimepiride</i> .....	140
		FREEDAVITE.....	37, 177, 186		



<i>glipizide</i> .....	140	HAIR,SKIN AND NAILS	HUMULIN N NPH U-100
<i>glipizide-metformin</i> .....	126, 140	.....	INSULIN.....
GLOPERBA.....	54, 149	.....	133, 135
GLUCAGEN HYPOKIT....	5, 131	HAIR,SKIN AND NAILS(FA-	HUMULIN R REGULAR U-
GLUCAGON (HCL)		BIOTIN).....	100 INSULN.....
EMERGENCY KIT.....	5, 131	.....	133, 139
GLUCAGON EMERGENCY		<i>halcinonide</i> .....	HUMULIN R U-500 (CONC)
KIT (HUMAN).....	5, 131	.....	INSULIN.....
GLUCOSE KETONE		<i>halobetasol propionate</i> .....	133, 139
CONTROL SOLN.....	89	HALOG.....	HUMULIN R U-500 (CONC)
GLUCOTROL XL.....	140	HARD NAILS.....	KWIKPEN.....
GLUMETZA.....	126	HAVRIX (PF).....	133, 139
<i>glyburide</i> .....	140	HEATHER.....	HYCANTIN.....
<i>glyburide micronized</i> .....	140	HEMADY.....	21
<i>glyburide-metformin</i> .....	126, 140	HEMANGEOL	<i>hydralazine</i> .....
GLYCOPHOS.....	94	.....	59
<i>glycopyrrolate</i> .....	26, 164	.....	<i>hydrochlorothiazide</i> .....
GLYXAMBI.....	130, 139	<i>heparin (porcine)</i> .....	65, 98
GOCOVRI.....	10, 27, 68	.....	<i>hydrocodone bitartrate</i> .....
GRALISE.....	70	HOMOCYSTEINE	<i>hydrocodone-</i>
<i>granisetron hcl</i> .....	108	FORMULA.....	<i>acetaminophen</i> .....
GRANIX.....	34	.....	70, 79
<i>griseofulvin microsize</i> .....	11	HORIZANT.....	<i>hydrocodone-ibuprofen</i> .....
<i>griseofulvin ultramicrosize</i> .....	11	70, 71	78, 79
<i>guanfacine</i> .....	54	HULIO(CF).....	<i>hydrocortisone</i> .....
GUARDIAN 4 GLUCOSE		.....	123, 168
SENSOR.....	197	HULIO(CF) PEN.....	<i>hydrocortisone acetate</i> .....
GUARDIAN 4		.....	168
TRANSMITTER.....	197	HUMALOG JUNIOR	<i>hydrocortisone butyrate</i> .....
GUARDIAN CONNECT		KWIKPEN U-100.....	<i>hydrocortisone valerate</i> .....
TRANSMITTER.....	197	133, 138	<i>hydrocortisone-acetic acid</i>
GUARDIAN LINK 3		HUMALOG KWIKPEN	.....
TRANSMITTER.....	197	.....	103, 105
GUARDIAN SENSOR 3.....	197	INSULIN.....	<i>hydrocortisone-aloe vera</i> .....
GVOKE.....	5, 131	133, 138	168
GVOKE HYOPEN 1-PACK		HUMALOG MIX 50-50	<i>hydromorphone</i> .....
.....	5, 131	.....	79
GVOKE HYOPEN 2-PACK		INSULN U-100.....	<i>hydroxychloroquine</i> .....
.....	5, 131	133, 135, 138	12, 150
GVOKE PFS 1-PACK		HUMALOG MIX 50-50	<i>hydroxyprogesterone</i>
SYRINGE.....	5, 131	.....	<i>caproate</i> .....
GVOKE PFS 2-PACK		KWIKPEN.....	137
SYRINGE.....	5, 132	133, 135, 138	<i>hydroxyurea</i> .....
HADLIMA.....	146	HUMALOG MIX 75-25	21
HADLIMA PUSH TOUCH.....	146	.....	<i>hydroxyzine hcl</i> .....
HADLIMA(CF).....	146	KWIKPEN.....	7, 73
HADLIMA(CF)		133, 135, 138	<i>hydroxyzine pamoate</i> .....
PUSH TOUCH.....	146	HUMALOG MIX 75-25(U-	7, 73
HAIR, SKIN AND NAILS-		100)INSULN.....	<i>hyoscyamine sulfate</i> .....
ARGAN OIL.....	37, 177, 186	133, 135, 138	5, 26
		HUMALOG TEMPO PEN(U-	HYRIMOZ PEN CROHN'S-
		100)INSULN.....	UC STARTER.....
		133, 138	147
		HUMALOG U-100 INSULIN	HYRIMOZ PEN PSORIASIS
		.....	STARTER.....
		133, 138	147
		HUMATROPE.....	HYRIMOZ(CF).....
		136	147
		HUMIRA.....	HYRIMOZ(CF) PEDI
		147	CROHN STARTER.....
		HUMIRA PEN.....	147
		147	HYRIMOZ(CF) PEN.....
		HUMIRA(CF).....	147
		147	HYSINGLA ER.....
		HUMIRA(CF) PEDI	80
		.....	HYZAAR.....
		CROHNS STARTER.....	44, 45, 65, 98
		147	<i>ibandronate</i> .....
		HUMIRA(CF) PEN.....	149
		147	IBSRELA.....
		HUMIRA(CF) PEN	118
		.....	IBU.....
		CROHNS-UC-HS.....	84
		147	IBU-200.....
		HUMIRA(CF) PEN PSOR-	84
		.....	<i>ibuprofen</i> .....
		UV-ADOL HS.....	84
		147	IBUPROFEN IB.....
		HUMULIN 70/30 U-100	84
		INSULIN.....	IBUPROFEN JR
		133, 135, 139	STRENGTH.....
		HUMULIN 70/30 U-100	84
		.....	<i>ibuprofen-famotidine</i> .....
		KWIKPEN.....	78, 118
		133, 135, 139	ICAPS MV.....
		HUMULIN N NPH INSULIN	177, 186
		.....	<i>icosapent ethyl</i> .....
		KWIKPEN.....	63
		133, 135	IDACIO(CF).....
			147

IDACIO(CF) PEN.....	147	<i>insulin lispro protamin-lispro</i>	134, 135, 138	KENALOG.....	168
IDACIO(CF) PEN CROHN-UC STARTR.....	147	INVOKAMET.....	126, 139	KERENDIA.....	63
IDACIO(CF) PEN PSORIASIS START.....	147	INVOKAMET XR.....	126, 139	KERYDIN.....	172
IDHIFA.....	21	INVOKANA.....	140	KESIMPTA PEN.....	145
ILEVRO.....	106	IOPIDINE.....	100	<i>ketoconazole</i> .....	13, 14, 164
ILUMYA.....	169	<i>ipratropium bromide</i>	26, 106, 153	KETODAN.....	14, 164
<i>imiquimod</i> .....	163	<i>ipratropium-albuterol</i>	26, 31, 153, 159	KETODAN KIT.....	14, 164
IMITREX.....	86	<i>irbesartan</i> .....	44, 45	<i>ketoprofen</i> .....	84
IMITREX STATDOSE PEN... 86		<i>irbesartan-hydrochlorothiazide</i>	44, 45, 65, 98	<i>ketorolac</i> .....	84, 107
IMITREX STATDOSE REFILL.....	86	IRON.....	37	<i>ketotifen fumarate</i> .....	100
INBRIJA.....	76	IRON (FERROUS SULFATE).....	37	KEVZARA.....	144
IN-CHECK NASAL WITH MASK.....	89	IRON 100 PLUS....	37, 186, 192	KIMONO CONDOMS(NON-LUBRICATED).....	151
IN-CHECK ORAL FLOW METER.....	89	ISIBLOOM.....	127	KIMONO MICROTHIN AQUA LUBE CON.....	151
INCRELEX.....	140	<i>isoniazid</i> .....	13	KIMONO MICROTHIN CONDOMS.....	151
INCRUSE ELLIPTA.....	26, 153	<i>isosorbide dinitrate</i> .....	63	KIMONO MICROTHIN LARGE CONDOMS.....	151
<i>indapamide</i> .....	66, 99	<i>isosorbide mononitrate</i> .....	63	KIMONO TEXTURED CONDOMS.....	151
INDERAL LA.....	28, 50, 51, 56, 62, 73	<i>isotretinoin</i> .....	171	KISQALI FEMARA CO-PACK.....	21, 125
INDERAL XL.....	28, 50, 51, 56, 62, 73	<i>isradipine</i> .....	53, 58, 59, 62, 67	KITABIS PAK.....	10
INDOCIN.....	84, 149	ISTALOL.....	103	KLAYESTA.....	172
<i>indomethacin</i> .....	84, 149	<i>itraconazole</i> .....	13	KLOR-CON/EF.....	94
INFANT FEVER REDUCER-PAIN RELF.....	71	<i>ivermectin</i> .....	11	KLOXXADO.....	82, 148
INFANT PAIN RELIEVER....	71	IYUZEH (PF).....	107	KOBEE.....	186
INFANTS GAS RELIEF.....	112	JAKAFI.....	21, 170	KONVOMEF.....	120
INFANT'S IBUPROFEN.....	84	JANTOVEN.....	33	K-PAX IMMUNE SUPPORT.....	37, 177, 186
INFANTS' PAIN AND FEVER.....	71	JANUMET.....	126, 130	K-PEC ANTIDIARRHEAL (BISM SUB).....	110, 111
INFANTS' PAIN RELIEF.....	71	JANUMET XR.....	126, 130	K-PHOS NO 2.....	91
INGREZZA.....	87	JANUVIA.....	130	K-PHOS ORIGINAL.....	91
INGREZZA INITIATION PK(TARDIV).....	87	JARDIANCE.....	140	KRAZATI.....	21
INNOPRAN XL.....	28, 50, 51, 56, 62, 73	JENCYCLA.....	127	KRINTAFEL.....	12
INPEFA.....	139	JENTADUETO.....	126, 130	KURVELO (28).....	128
INQOVI.....	21	JENTADUETO XR.....	126, 130	<i>labetalol</i>	28, 30, 43, 50, 51, 56, 65
<i>insulin asp prt-insulin aspart</i>	133, 135, 138	JESDUVROQ.....	33, 34	<i>lactulose</i> .....	92
<i>insulin aspart u-100</i>	133, 134, 138	JUBLIA.....	164	LAGEVRIO (EUA).....	17
<i>insulin degludec</i> .....	134, 135	JULEBER.....	128	<i>lamivudine</i> .....	15
<i>insulin glargine u-300 conc</i>	134, 135	JUNEL 1/20 (21).....	128	<i>lancets</i> .....	89
<i>insulin glargine-yfgn</i> .....	134, 136	JUNEL FE 1.5/30 (28).....	128	<i>lansoprazole</i> .....	120
<i>insulin lispro</i> .....	134, 138, 139	JYLAMVO.....	21, 143	<i>lanthanum</i> .....	92
		KAOPECTATE (BISMUTH SUBSALICY).....	110, 111	LANTUS SOLOSTAR U-100 INSULIN.....	134, 136
		KAOPECTATE EX STR (BISMUTH SS).....	110, 111	LANTUS U-100 INSULIN.....	134, 136
		KAPSPARGO SPRINKLE.....	32, 50, 51, 56	LARIN 1.5/30 (21).....	128
		KATERZIA.....	53, 58, 59, 62, 67	LARIN 1/20 (21).....	128
		KAZANO.....	126, 130		
		KELNOR 1/35 (28).....	128		

LARIN FE 1.5/30 (28).....	128	LIQREV.....	64, 157, 159	LUMAKRAS.....	21
LARIN FE 1/20 (28).....	128	<i>lisinopril</i> .....	46, 48	LUMIGAN.....	107
<i>latanoprost</i> .....	107	<i>lisinopril-hydrochlorothiazide</i>		LUTERA (28).....	128
LAXATIVE (BISACODYL)...	115	.....	46, 48, 65, 98	LUZU.....	165
LAXATIVE (SENNOSIDES)	115	LITE TOUCH-MEDIUM		LYSODREN.....	21
LAXATIVE PEG 3350.....	115	MASK.....	90	LYUMJEV KWIKPEN U-100	
LAXATIVE PILLS.....	115	LITEAIRE MDI CHAMBER...	90	INSULIN.....	134, 139
LAXATIVE PILLS		LITETOUCH-LARGE MASK..	90	LYUMJEV KWIKPEN U-200	
REGULAR.....	115	LITETOUCH-SMALL MASK..	90	INSULIN.....	134, 139
LEENA 28.....	128	LITFULO.....	170	LYUMJEV TEMPO PEN(U-	
<i>leflunomide</i> .....	145, 150	LITTLE REMEDIES FEVER		100)INSULN.....	134, 139
<i>lenalidomide</i> .....	21, 150	AND PAIN.....	71	LYUMJEV U-100 INSULIN	
LESCOL XL.....	61	LIVALO.....	61	.....	134, 139
LETAIRIS.....	67, 159	LIVTENCITY.....	14	MAG GLYCINATE.....	94
<i>letrozole</i> .....	21, 125	LOCOID.....	168	MAG-AL PLUS.....	110, 112
<i>leucovorin calcium</i> .....	5	LOCOID LIPOCREAM.....	168	MAG-AL PLUS EXTRA	
LEUKERAN.....	21	LODOSYN.....	76	STRENGTH.....	110, 113
LEUKINE.....	34	LOFENA.....	73, 84, 172	MAG-G.....	94
<i>leuprolide</i> .....	21, 132	LOMAIRA.....	68	MAGINEX.....	95
<i>leuprolide (3 month)</i> .....	21, 132	LONSURF.....	21	<i>magnesium</i> .....	95
<i>levabuterol hcl</i> .....	31, 159	<i>loperamide</i> .....	111	MAGNESIUM (OXIDE/AA	
<i>levabuterol tartrate</i> .....	31, 159	LOPID.....	60	CHELATE).....	95
<i>levamlodipine</i> .....	53, 58, 59, 62, 67	LOPRESSOR.....	32, 50, 51, 56	<i>magnesium amino acid</i>	
LEVEMIR FLEXPEN...	134, 136	LOPROX (AS OLAMINE)...	169	<i>chelate</i> .....	95
LEVEMIR U-100 INSULIN		LOPROX KIT.....	169, 173	<i>magnesium chloride</i> .....	72, 95
.....	134, 136	LOQTORZI.....	21	<i>magnesium citrate</i> .....	95, 115
<i>levobunolol</i> .....	104	<i>loratadine</i> .....	9, 158	<i>magnesium gluconate</i> .....	95
<i>levocetirizine</i> .....	9, 158	LORZONE.....	27	<i>magnesium hydroxide</i> .....	115
<i>levofloxacin</i> .....	13, 19, 102, 162	<i>losartan</i> .....	44, 45	<i>magnesium oxide</i> .....	110
LEVONEST (28).....	128	<i>losartan-hydrochlorothiazide</i>		<i>magnesium sulfate</i> ..	48, 72, 148
<i>levonorgestrel-ethinyl estrad</i>	128	.....	44, 46, 65, 98	<i>magnesium sulfate in d5w</i>	
<i>levorphanol tartrate</i> .....	80	LOTENSIN.....	47, 48	.....	48, 72, 148
<i>levothyroxine</i> .....	141	LOTENSIN HCT..	47, 48, 65, 98	<i>magnesium sulfate in water</i>	
LEVOXYL.....	141	<i>loteprednol etabonate</i> .....	105	.....	48, 72, 148
LIALDA.....	113	LOTREL		MAGOX.....	110
LICART.....	78, 172	.....	47, 48, 53, 58, 59, 62, 67	MAGTAB.....	95
LICE KILLING.....	173	LOTRIMIN AF		<i>malathion</i> .....	173
LICE PYRINYL SHAMPOO.	173	(CLOTRIMAZOLE).....	164	MAPAP	
LICE TREATMENT.....	173	LOTRONEX.....	113	(ACETAMINOPHEN).....	71
LICE TREATMENT		<i>lovastatin</i> .....	61	MARLISSA (28).....	128
(PERMETHRIN).....	173	LOVAZA.....	63	MATULANE.....	22
<i>lidocaine</i> .....	163	LOVENOX.....	35	MATZIM LA.....	53, 57
<i>lidocaine hcl</i> .....	107, 163	LOW-OGESTREL (28).....	128	MAVENCLAD (10 TABLET	
LIDOCAINE PAIN RELIEF..	163	<i>lubiprostone</i> .....	117	PACK).....	22, 142
LIDOCAINE VISCOUS.....	107	LUBRICANT (P-GLYCOL-		MAVENCLAD (4 TABLET	
<i>lidocaine-prilocaine</i> .....	163	GLYCERIN).....	106	PACK).....	22, 142
LIKMEZ....	10, 16, 114, 162, 173	LUBRICANT EYE (PG-PEG		MAVENCLAD (5 TABLET	
<i>linezolid</i> .....	18	400).....	106	PACK).....	22, 142
LINZESS.....	118	LUBRICATING PLUS.....	106	MAVENCLAD (6 TABLET	
<i>liothyronine</i> .....	141	LUCEMYRA.....	26	PACK).....	22, 142
LIPITOR.....	61	LUDENT FLUORIDE.....	88	MAVENCLAD (7 TABLET	
LIPOFEN.....	60	<i>luliconazole</i> .....	165	PACK).....	22, 142



MAVENCLAD (8 TABLET PACK).....	22, 142	METHADONE INTENSOL.....	80	MINI WRIGHT PEAK FLOW METER.....	90
MAVENCLAD (9 TABLET PACK).....	22, 142	METHADOSE.....	80	<i>minocycline</i> .....	20
MAXALT.....	86	<i>methenamine hippurate</i> .....	20	<i>minoxidil</i> .....	59
MAXALT-MLT.....	87	<i>methenamine mandelate</i> .....	20	MINTOX MAXIMUM STRENGTH.....	110, 113
MAYZENT.....	145	<i>methimazole</i> .....	125	<i>mirabegron</i> .....	175
MAYZENT STARTER(FOR 1MG MAINT).....	145	<i>methocarbamol</i> .....	27	MIRAPEX ER.....	77
MAYZENT STARTER(FOR 2MG MAINT).....	145	<i>methotrexate sodium</i> .....	22, 143	<i>misoprostol</i> .....	120
<i>meclizine</i> .....	7, 113	<i>methotrexate sodium (pf)</i> .....	22, 143	MITIGARE.....	54, 149
<i>meclofenamate</i> .....	84	<i>methylidopa</i> .....	26, 54	M-M-R II (PF).....	25
<i>medroxyprogesterone</i> .....	137	<i>methylidopa-</i> <i>hydrochlorothiazide</i> .....	26, 55, 66, 98	MODERNA COVID 23- 24(6M-11Y)PF.....	25
MEDTYCHOLL-B COMPLEX-LIVER.....	186	<i>methylergonovine</i> .....	152	<i>moexipril</i> .....	47, 48
<i>mefenamic acid</i> .....	84	<i>methylprednisolone</i> .....	123	<i>mometasone</i> .....	105, 155, 168
<i>mefloquine</i> .....	12	<i>metoclopramide hcl</i> .....	119	MONISTAT 3.....	165
MEGA BIOTIN.....	186	<i>metolazone</i> .....	66, 99	MONISTAT 7.....	165
MEGA MULTI FOR WOMEN .....	37, 95, 177, 186	<i>metoprolol succinate</i> .....	32, 50, 51, 56	MONOCAPS.....	37, 177, 187
MEGA MULTIVITAMIN FOR MEN.....	177, 186	<i>metoprolol ta-</i> <i>hydrochlorothiaz</i> .....	32, 50, 51, 56, 66, 98	MONO-LINYAH.....	128
<i>megestrol</i> .....	22, 137	<i>metoprolol tartrate</i> .....	32, 50, 51, 56	<i>montelukast</i> .....	154
<i>meloxicam</i> .....	84	<i>metronidazole</i> .....	10, 16, 114, 162, 173	<i>morphine</i> .....	80
<i>meloxicam submicronized</i> .....	84	<i>mexiletine</i> .....	55	<i>morphine concentrate</i> .....	80
<i>melphalan</i> .....	22	MIBELAS 24 FE.....	128	MOTEGRITY.....	119
<i>memantine</i> .....	76	MICARDIS.....	44, 46	MOUNJARO.....	132
MENEST.....	131	MICARDIS HCT... ..	44, 46, 66, 98	MOUTHPIECE.....	90
MEN'S DAILY.....	177, 186	<i>miconazole nitrate</i> .....	165	MOVANTIK.....	119
MEN'S MULTIVITAMIN GUMMIES.....	177, 186	<i>miconazole nitrate-zinc ox-</i> <i>pet</i> .....	165	<i>moxifloxacin</i> .....	102, 162
MEN'S ONE DAILY .....	177, 186, 195	MICONAZOLE-3.....	165	M-PAP.....	71
MENTAX.....	166	MICONAZOLE-3 PREFIL, CREAM, WIPE.....	165	MS CONTIN.....	80
MENVEO A-C-Y-W-135-DIP (PF).....	25	MICONAZOLE-7.....	165	MULTI COMPLETE WITH IRON.....	37, 177, 187
<i>meperidine</i> .....	80	MICROCHAMBER.....	90	MULTI FOR HER .....	37, 95, 177, 187, 195
<i>mercaptopurine</i> .....	22, 143	MICROGESTIN 1.5/30 (21).....	128	MULTI-DAY WITH IRON .....	37, 177, 187
MERIBIN.....	187	MICROGESTIN FE 1.5/30 (28).....	128	MULTIPLE VITAMIN- MINERALS.....	177
<i>mesalamine</i> .....	113	MICROGESTIN FE 1/20 (28).....	128	MULTIPLE VITAMINS.....	177
MESNEX.....	5	MICROLIFE PEAK FLOW METER.....	90	MULTI-VIT WITH FLUORIDE-IRON.. ..	37, 150, 177
METAMUCIL (SUGAR).....	115	MICROSPACER.....	90	<i>multivitamin</i> .....	177
METAMUCIL (WITH SUGAR).....	115	<i>midazolam</i> .....	74	MULTI-VITAMIN WITH FLUORIDE.....	150, 177, 178
METAMUCIL MULTIHEALTH FIBER.....	115	<i>midazolam (pf)</i> .....	74	<i>multivitamin with iron</i> .....	37, 178
METAMUCIL SUGAR-FREE (ASPART).....	115	<i>midodrine</i> .....	26	<i>multivit-min-iron fum-folic ac</i> .....	37, 178, 187
<i>metaxalone</i> .....	27	MIEBO (PF).....	103	<i>mupirocin</i> .....	162
<i>metformin</i> .....	126	<i>miglitol</i> .....	124	<i>mupirocin calcium</i> .....	162
<i>methadone</i> .....	80	MILK OF MAGNESIA.....	115	MVC-FLUORIDE.....	150, 178
		<i>mineral oil</i> .....	115	<i>mv-min-folic acid-lutein</i> .....	178, 187
				MVW COMPLETE FORMUL MULTIVIT.....	178, 194, 195

MVW COMPLETE FORMULATION D3000	<i>neomycin-bacitracin-poly-hc</i>	NON-ASPIRIN EXTRA STRENGTH
..... 178, 194, 195	..... 102, 105	..... 71
MY WAY	<i>neomycin-bacitracin-polymyxin</i>	NON-ASPIRIN PAIN RELIEF
..... 128	..... 102	..... 71
<i>mycophenolate mofetil</i>	<i>neomycin-polymyxin b-dexameth</i>	NORA-BE
..... 142	..... 102, 105	..... 128
<i>mycophenolate mofetil (hcl)</i>	<i>neomycin-polymyxin-gramicidin</i>	NORDITROPIN FLEXPRO
..... 142	..... 102	..... 137
<i>mycophenolate sodium</i>	<i>neomycin-polymyxin-hc</i>	<i>noreth-ethinyl estradiol-iron</i>
..... 142	..... 102	..... 128
MYCOZYL AC	NEPHPLEX RX	<i>norethindrone (contraceptive)</i>
..... 165	..... 187, 192	..... 128
MYFEMBREE	NEPHRON FA	<i>norethindrone acetate</i>
..... 125, 131, 137	..... 37, 187, 192	..... 137
MYLERAN	NESINA	<i>norethindrone ac-eth estradiol</i>
..... 22	..... 130	..... 128, 131, 137
MYNEPHROCAPS	NESTABS	<i>norethindrone-e.estradiol-iron</i>
..... 187, 192	..... 37, 95, 178, 187	..... 128
MYRBETRIQ	NESTABS DHA	NORGESIC
..... 175	..... 38, 95, 178, 187	..... 32, 86
MY-VITALIFE	NEUAC	NORGESIC FORTE
..... 178	..... 15, 162, 171	..... 32, 86
<i>nabumetone</i>	NEUAC KIT	<i>norgestimate-ethinyl estradiol</i>
..... 84	..... 15, 162, 171	..... 128
<i>nadolol</i>	NEULASTA	NORLIQVA
..... 50, 51, 56	..... 34	..... 53, 58, 59, 62, 67
<i>naftifine</i>	NEULASTA ONPRO	NORTREL 0.5/35 (28)
..... 160	..... 34	..... 128
NAFTIN	NEUPOGEN	NORTREL 1/35 (28)
..... 160	..... 34	..... 129
NALFON	NEUPRO	NORVASC
..... 84	..... 77	..... 53, 58, 59, 62, 67
<i>naloxone</i>	NEVANAC	NOURIANZ
..... 82, 148	..... 107	..... 68
NAMENDA TITRATION PAK	NEWGEN	NOVOLIN 70/30 U-100
..... 76	..... 38, 95, 178, 187	INSULIN
NAMENDA XR	NEXICLON XR	..... 134, 135, 139
..... 76	..... 26, 55	NOVOLIN 70-30 FLEXPEN U-100
NAMZARIC	NEXIUM	..... 134, 135, 139
..... 29, 76	..... 120	NOVOLIN N FLEXPEN
NANO VM 1-3	NEXIUM PACKET	..... 134, 135
..... 37, 178, 187	..... 120	NOVOLIN N NPH U-100
NANO VM 4-8	NEXLETOL	INSULIN
..... 37, 178, 187	..... 43	..... 134, 135
NANOVM 9-18	NEXLIZET	NOVOLIN R FLEXPEN
..... 37, 178	..... 43	..... 134, 139
NANOVM T-F	NGENLA	NOVOLIN R REGULAR
..... 37, 178	..... 136	U100 INSULIN
NAPHCON-A	<i>niacin</i>	..... 134, 139
..... 108	..... 49	NOVOLOG FLEXPEN U-100
NAPRELAN CR	<i>niacin (inositol niacinate)</i>	..... 134, 139
..... 84	..... 49	NOVOLOG MIX 70-30 U-100
<i>naproxen</i>	NIACIN FLUSH FREE	..... 134, 135, 139
..... 85	..... 49	NOVOLOG MIX 70-30FLEXPEN U-100
<i>naproxen sodium</i>	NIACIN NO FLUSH	..... 134, 135, 139
..... 85	..... 49	NOVOLOG MIX 70-30FLEXPEN U-100
<i>naproxen-esomeprazole</i>	<i>niacinamide</i>	..... 134, 135, 139
..... 78, 120	..... 187	NOVOLOG PENFILL U-100
<i>naratriptan</i>	<i>nicardipine</i>	INSULIN
..... 87	..... 53, 58, 59, 62, 67	..... 134, 139
NARCAN	<i>nicotine</i>	NOVOLOG U-100 INSULIN
..... 82, 148	..... 32	ASPART
NASAL ALLERGY	<i>nicotine (polacrilex)</i>	..... 134, 139
..... 105, 155	..... 32	NOXAFIL
NASALCROM	NICOTROL NS	..... 14
..... 100, 155	..... 32	NP THYROID
NASONEX 24HR ALLERGY	<i>nifedipine</i>	..... 141
..... 105, 155	..... 53, 58, 59, 62, 67	NUBEQA
<i>nateglinide</i>	NIKKI (28)	..... 22
..... 136	..... 128	NUCALA
NATESTO	<i>nilutamide</i>	..... 154
..... 124	..... 22	NUCYNTA
NATURAL DAILY FIBER	<i>nimodipine</i>	..... 80
..... 115	..... 53, 58, 59, 62, 67	NUCYNTA ER
NATURAL FIBER LAXATIVE (SUGAR)	<i>nisoldipine</i>	..... 80
..... 115	..... 53, 58, 59, 62, 67	NU-MAG
NATURAL FIBER LAXATIVE(ASPART)	<i>nitazoxanide</i>	..... 95
..... 116	..... 12	NURTEC ODT
NATURAL SENNA LAXATIVE	NITRO-BID	..... 75
..... 116	..... 63	
NATURAL TEARS (PF)	<i>nitrofurantoin macrocrystal</i>	
..... 106	..... 20	
NATURAL VEG LAXATIVE(SENNOSID)	<i>nitrofurantoin monohyd/m-cryst</i>	
..... 116	..... 20	
<i>nebivolol</i>	<i>nitroglycerin</i>	
..... 28, 50	..... 63	
<i>nelarabine</i>	NIVESTYM	
..... 22	..... 34	
<i>neomycin</i>	NIX CREME RINSE	
..... 10, 102, 162	..... 173	
	NON-ASPIRIN	
	..... 71	

NUTROPIN AQ NUSPIN.....	137	ONE DAILY MAXIMUM	38, 179, 188	ONE-A-DAY WOMEN'S	HEALTHY SKIN	38, 95, 180, 188
NUVESSA.....	16	ONE DAILY MEN'S 50	PLUS MEMORY.....	179, 188	ONE-A-DAY WOMEN'S	PETITES.....
NYAMYC.....	172	ONE DAILY MULTI-VIT W-	MINERAL.....	38, 179	ONEXTON.....	15, 162, 171
<i>nystatin</i> .....	18, 172	ONE DAILY MULTIVITAMIN	.....	179	ONGENTYS.....	75
<i>nystatin-triamcinolone</i> .....	173	ONE DAILY MULTIVIT-	IRON(FOLIC).....	38, 179, 188	ONGLYZA.....	130
NYSTOP.....	173	ONE DAILY PLUS IRON	.....	38, 179, 188	ONUREG.....	22
NYVEPRIA.....	34	ONE DAILY PLUS	MINERALS.....	179	ONZETRA XSAIL.....	87
<i>octreotide acetate</i> .....	140	ONE DAILY WOMEN 50	PLUS.....	179, 188	OPCICON ONE-STEP.....	129
OCUFLOX.....	19, 102	ONE DAILY WOMEN'S	.....	38, 95, 179, 188	OPCON-A.....	108
OCUTABS.....	178	ONE DAILY WOMENS 50	PLUS.....	179, 188	OPSUMIT.....	67, 159
ODOMZO.....	22	ONE WAY VALVED	MOUTHPIECE.....	90	OPTICHAMBER ADULT	MASK-LARGE.....
<i>ofloxacin</i> .....	19, 102	ONE-A-DAY ENERGY	.....	38, 95, 179, 188	OPTICHAMBER DIAMOND	LG MASK.....
<i>olmesartan</i> .....	44, 46	ONE-A-DAY ESSENTIAL....	179	ONE-A-DAY MAXIMUM	FORMULA.....	179
<i>olmesartan-amlodipin-</i>		ONE-A-DAY MEN	VITACRAVES.....	179, 188	ONE-A-DAY MEN	50PLUS(GINKGO).....
<i>hcthiazid</i>		ONE-A-DAY MENOPAUSE	FORMULA.....	95, 179, 188	ONE-A-DAY MEN'S	MULTIVITAMIN... 179, 188, 195
.....	44, 46, 53, 58, 59, 66, 98	ONE-A-DAY MEN'S	ONE-A-DAY TEEN	ADVANTAGE.. 38, 95, 179, 188	ONE-A-DAY MEN'S	ONE-A-DAY VITACRAVES
<i>olmesartan-</i>		ONE-A-DAY MEN'S	ONE-A-DAY VITACRAVES	IMMUNITY.....	179, 188	ONE-A-DAY VITACRAVES
<i>hydrochlorothiazide</i>		ONE-A-DAY MEN'S	OMEGA-3.....	179, 188	ONE-A-DAY	WEIGHTSMART ....38, 179, 188
.....	44, 46, 66, 98	ONE-A-DAY MEN'S	ONE-A-DAY	WOMEN	VITACRAVES.....	180, 188
<i>olopatadine</i> .....	100	ONE-A-DAY MEN'S	ONE-A-DAY WOMEN	ACTIVE.....	38, 95, 180, 188	
OLUMIANT.....	144	ONE-A-DAY MEN'S	ONE-A-DAY WOMEN'S			
OLUX.....	168	ONE-A-DAY MEN'S	ONE-A-DAY WOMEN'S			
OMECLAMOX-PAK. 11, 17, 120		ONE-A-DAY MEN'S	ONE-A-DAY WOMEN'S			
<i>omega 3-dha-epa-fish oil</i> .....	49	ONE-A-DAY MEN'S	ONE-A-DAY WOMEN'S			
<i>omega-3 acid ethyl esters</i> ....	63	ONE-A-DAY MEN'S	ONE-A-DAY WOMEN'S			
<i>omega-3 fatty acids</i> .....	49	ONE-A-DAY MEN'S	ONE-A-DAY WOMEN'S			
<i>omega-3 fatty acids-fish oil</i> ...	49	ONE-A-DAY MEN'S	ONE-A-DAY WOMEN'S			
<i>omeprazole</i> .....	120	ONE-A-DAY MEN'S	ONE-A-DAY WOMEN'S			
<i>omeprazole magnesium</i> .....	120	ONE-A-DAY MEN'S	ONE-A-DAY WOMEN'S			
<i>omeprazole-sodium</i>		ONE-A-DAY MEN'S	ONE-A-DAY WOMEN'S			
<i>bicarbonate</i> .....	120	ONE-A-DAY MEN'S	ONE-A-DAY WOMEN'S			
OMNARIS.....	105, 123, 155	ONE-A-DAY MEN'S	ONE-A-DAY WOMEN'S			
OMNICAP.....	178, 187	ONE-A-DAY MEN'S	ONE-A-DAY WOMEN'S			
OMNITROPE.....	137	ONE-A-DAY MEN'S	ONE-A-DAY WOMEN'S			
ONCOVITE.....	178	ONE-A-DAY MEN'S	ONE-A-DAY WOMEN'S			
<i>ondansetron</i> .....	108	ONE-A-DAY MEN'S	ONE-A-DAY WOMEN'S			
<i>ondansetron hcl</i> .....	108	ONE-A-DAY MEN'S	ONE-A-DAY WOMEN'S			
ONE DAILY.....	178, 187	ONE-A-DAY MEN'S	ONE-A-DAY WOMEN'S			
ONE DAILY		ONE-A-DAY MEN'S	ONE-A-DAY WOMEN'S			
CALCIUM/IRON.....	38, 178	ONE-A-DAY MEN'S	ONE-A-DAY WOMEN'S			
ONE DAILY COMPLETE		ONE-A-DAY MEN'S	ONE-A-DAY WOMEN'S			
.....	38, 178, 187	ONE-A-DAY MEN'S	ONE-A-DAY WOMEN'S			
ONE DAILY ENERGY.....	179	ONE-A-DAY MEN'S	ONE-A-DAY WOMEN'S			
ONE DAILY ESSENTIAL		ONE-A-DAY MEN'S	ONE-A-DAY WOMEN'S			
.....	179, 187	ONE-A-DAY MEN'S	ONE-A-DAY WOMEN'S			
ONE DAILY FOR MEN 179, 187		ONE-A-DAY MEN'S	ONE-A-DAY WOMEN'S			
ONE DAILY FOR MEN 50		ONE-A-DAY MEN'S	ONE-A-DAY WOMEN'S			
PLUS ADV.....	179, 187	ONE-A-DAY MEN'S	ONE-A-DAY WOMEN'S			
ONE DAILY FOR WOMEN		ONE-A-DAY MEN'S	ONE-A-DAY WOMEN'S			
.....	38, 179, 187	ONE-A-DAY MEN'S	ONE-A-DAY WOMEN'S			
ONE DAILY HEALTHY		ONE-A-DAY MEN'S	ONE-A-DAY WOMEN'S			
WEIGHT.....	38, 179, 187	ONE-A-DAY MEN'S	ONE-A-DAY WOMEN'S			

OSMOLEX ER.....	10, 27, 68	PARLODEL.....	77	<i>phenazopyridine</i> .....	163
OTEZLA.....	145, 150, 173	PAROEX ORAL RINSE.....	103	<i>phendimetrazine tartrate</i> .....	68
OTEZLA STARTER		<i>paromomycin</i> .....	10	<i>phentermine</i> .....	68
.....	145, 150, 173	PARVLEX.....	38, 188, 192	<i>phenylephrine hcl</i> .....	108
<i>oxaprozin</i> .....	85	PATADAY ONCE DAILY		PHEXXI.....	151
OXBRYTA.....	33	RELIEF.....	100	PHILITH.....	129
OXERVATE.....	103	PATADAY TWICE DAILY		PHILLIPS.....	110
<i>oxiconazole</i> .....	165	RELIEF.....	100	PHILLIPS MILK OF	
OXISTAT.....	165	PATANASE.....	100	MAGNESIA.....	116
<i>oxybutynin chloride</i> .....	174	PAXLOVID.....	14	<i>phytonadione (vitamin k1)</i> 5,	195
<i>oxycodone</i> .....	80, 81	P-COL RITE.....	116	PIKO 1.....	90
<i>oxycodone-acetaminophen</i>		PEAK AIR PEAK FLOW		<i>pilocarpine hcl</i> .....	29, 107
.....	71, 81	METER.....	90	<i>pimecrolimus</i> .....	169
OXYCONTIN.....	81	PEDIALYTE.....	96	PIMTREA (28).....	129
<i>oxymorphone</i> .....	81	PEDIALYTE ADVANCED		<i>pindolol</i> .....	28, 50, 51, 56, 62
OXYTROL.....	174	CARE.....	96	PINK BISMUTH.....	110, 111
OXYTROL FOR WOMEN...	174	PEDIALYTE FREEZER		PINK BISMUTH MAXIMUM	
OYSCO 500/D.....	96, 194	POPS.....	96	STRENGTH.....	110, 111
OYSTER SHELL + D3...	96, 194	PEDIALYTE SINGLES.....	96	<i>pioglitazone</i> .....	141
OYSTER SHELL CALCIUM..	96	PEDIATRIC ELECTROLYTE	96	<i>pioglitazone-glimepiride</i>	
OYSTER SHELL CALCIUM		PEDIATRIC ENEMA.....	116	.....	140, 141
500.....	96	PEDIATRIC FREEZER		<i>pioglitazone-metformin</i>	126, 141
OYSTER SHELL CALCIUM-		POPS.....	96	<i>piroxicam</i> .....	85
VIT D3.....	96, 194	PEDIATRIC MEDIUM MASK.	90	<i>pitavastatin calcium</i> .....	61
OYSTERCAL-D.....	96, 194	PEDIATRIC PANDA MASK...	90	PLAVIX.....	41
OZEMPIC.....	132	PEDIATRIC SMALL MASK...	90	PLEGRIDY.....	144
PAIN RELIEF		PEDIAVANCE.....	96	PNEUMOVAX-23.....	25
(ACETAMINOPHEN).....	71	<i>peg 3350-electrolytes</i> .....	116	<i>pnv cmb#95-ferrous</i>	
PAIN RELIEF ES		<i>peg-electrolyte soln</i> .....	116	<i>fumarate-fa</i> .....	38, 180, 188
(ACETAMINOPHEN).....	71	<i>pemetrexed disodium</i> .....	22	POCKET CHAMBER.....	90
PAIN RELIEVER		<i>penciclovir</i> .....	163	POCKET PEAK FLOW	
(ACETAMINOPHEN).....	71	<i>penicillin v potassium</i> .....	16	METER.....	90
PAIN RELIEVER		PENNSAID.....	78, 172	<i>podofilox</i> .....	171
ES(ACETAMINOPHN).....	71	PENTASA.....	113	<i>polyethylene glycol 3350</i> ....	116
PALFORZIA (LEVEL 1).....	23	<i>pentazocine-naloxone</i> .....	82	<i>polymyxin b sulf-</i>	
PALFORZIA (LEVEL 2).....	23	<i>pentoxifylline</i> .....	35	<i>trimethoprim</i> .....	18, 102, 162
PALFORZIA (LEVEL 3).....	23	PEPTO-BISMOL.....	110, 111	<i>polyvinyl alcohol</i> .....	106
PALFORZIA (LEVEL 4).....	23	PEPTO-BISMOL MAX ST		POMALYST.....	22, 150
PALFORZIA (LEVEL 5).....	23	.....	110, 111	PONVORY.....	145
PALFORZIA (LEVEL 6).....	24	PEPTO-BISMOL TO-GO		PONVORY 14-DAY	
PALFORZIA (LEVEL 7).....	24	.....	110, 111	STARTER PACK.....	145
PALFORZIA (LEVEL 8).....	24	PERCOCET.....	71, 81	PORTIA 28.....	129
PALFORZIA (LEVEL 9).....	24	PERDIEM OVERNIGHT		<i>posaconazole</i> .....	14
PALFORZIA (LEVEL 10).....	24	RELIEF.....	116	<i>potassium chloride</i> .....	96
PALFORZIA (LEVEL 11 UP-		PERFOROMIST.....	31, 159	<i>potassium citrate</i> .....	91
DOSE).....	24	<i>perindopril erbumine</i> .....	47, 48	<i>potassium citrate-citric acid</i> ..	92
PALFORZIA INITIAL DOSE..	24	<i>permethrin</i> .....	173	<i>potassium phosphate m-/d-</i>	
PALFORZIA LEVEL 11		PERSONAL BEST FULL		<i>basic</i> .....	96
MAINTENANCE.....	24	RANGE.....	90	PRADAXA.....	34
PANDA MASK.....	90	PERTZYE.....	117	PRALUENT PEN.....	64
PANDEL.....	168	PHARBECHLOR.....	7, 154	<i>pramipexole</i> .....	77
<i>pantoprazole</i> .....	120, 121	PHARBETOL.....	71	<i>prasugrel</i> .....	41



<i>pravastatin</i> .....	61	PRO COMFORT SPACER- CHILD MASK.....	90	<i>pyridostigmine bromide</i> .....	29
<i>prazosin</i> .....	29, 43	PROAIR DIGIHALER....	31, 159	<i>pyrimethamine</i> .....	12
PRECISION XTRA B- KETONE.....	90	PROAIR RESPICLICK..	31, 159	QBRELIS.....	47, 48
PRECISION XTRA MONITOR.....	90	<i>probenecid</i> .....	99, 149	QNASL.....	105, 155
PRECISION XTRA TEST.....	91	<i>probenecid-colchicine</i> ....	99, 149	QTERN.....	130, 140
PRECOSE.....	124	PRO-CAL.....	97	QUESTRAN.....	52
<i>prednicarbate</i> .....	168	PROCARDIA XL .....	53, 58, 59, 62, 67	QUESTRAN LIGHT.....	52
<i>prednisolone</i> .....	123	PROCARE SPACER WITH ADULT MASK.....	90	QUIN B STRONG.....	189, 192
<i>prednisolone acetate</i> .....	105	PROCARE SPACER WITH CHILD MASK.....	90	<i>quinapril</i> .....	47, 48
<i>prednisolone sodium phosphate</i> .....	105, 123	PROCERV HP .....	39, 181, 189, 195	<i>quinapril-hydrochlorothiazide</i> .....	47, 48, 66, 98
<i>prednisone</i> .....	123	PROCHAMBER.....	91	<i>quinidine sulfate</i> .....	12, 55
PREHEVBRIO (PF).....	25	<i>prochlorperazine</i> .....	83, 113	QUINTABS.....	181, 189
PREMARIN.....	131	<i>prochlorperazine maleate</i> .....	83, 113	QUINTABS-M..	39, 97, 181, 189
PREMPHASE.....	131	PROCRIT.....	34	QUINTABS-M IRON FREE .....	181, 189
PREMPRO.....	131	PROCTOCORT.....	168	QULIPTA.....	75
PRENATABS RX .....	38, 96, 180, 188	PROCTOSOL HC.....	168	QVAR REDIHALER....	123, 156
PRENATAL.....	39, 180, 189	<i>progesterone</i> .....	137	<i>rabeprazole</i> .....	121
PRENATAL COMPLETE .....	39, 96, 180, 188	<i>progesterone micronized</i> ....	137	<i>raloxifene</i> .....	130, 149
PRENATAL DHA.....	118	PROGLYCEM.....	125	<i>ramipril</i> .....	47, 48
PRENATAL FORMULA .....	39, 180, 189	PROLENSA.....	107	<i>ranolazine</i> .....	54
PRENATAL MULTI- DHA(WITH VIT K). 39, 180, 189		<i>promethazine</i> .....	7, 74, 154	RAPAFLO.....	30
PRENATAL MULTIVITAMINS... 39, 180, 189		PROMETRIUM.....	137	<i>rasagiline</i> .....	77
PRENATAL PLUS (CALCIUM CARB) .....	39, 97, 180, 189	PROMOLAXIN.....	116	READY-TO-USE ENEMA... 116	
PRENATAL TABLET .....	39, 97, 180, 189	<i>propafenone</i> .....	55	READY-TO-USE ENEMA (MIN OIL).....	116
PRENATAL VITAMIN PLUS LOW IRON.....	39, 97, 180, 189	<i>propracetamol</i> .....	107	REBIF (WITH ALBUMIN)....	144
PRENATAL VITAMIN WITH MINERALS.....	39, 97, 181, 189	<i>propranolol</i> .....	28, 50, 51, 56, 62, 73	REBIF REBIDOSE.....	144
<i>pretomanid</i> .....	13	<i>propranolol- hydrochlorothiazid</i> .....	28, 50, 51, 56, 66, 98	REBIF TITRATION PACK... 144	
PREVACID.....	121	<i>propylthiouracil</i> .....	125	RECLIPSEN (28).....	129
PREVACID 24HR.....	121	PRORENAL... 39, 189, 192, 194		RECOMBIVAX HB (PF).....	25
PREVACID SOLUTAB.....	121	PRORENAL QD .....	39, 181, 189, 194	REESE'S PINWORM MEDICINE.....	11
PREVALITE.....	52	PROSCAR.....	148, 166	REFRESH LACRI-LUBE....	106
PREVNAR 13 (PF).....	25	PROTECT CARDIO AF .....	181, 189	REFRESH LIQUIGEL.....	106
PREVNAR 20 (PF).....	25	PROTECT PLUS SO... 181, 189		REFRESH P.M.....	106
PRIFTIN.....	13, 19	PROTONIX.....	121	RELAFEN DS.....	85
PRILOSEC.....	121	PROVERA.....	138	RELENZA DISKHALER.....	16
<i>primaquine</i> .....	12	PULMICORT.....	123, 156	RELEUKO.....	34
PRIMEAIRE.....	90	PULMICORT FLEXHALER .....	123, 156	RELISTOR.....	119
PRO COMFORT SPACER- ADULT MASK.....	90	PULMOZYME.....	99, 155	RELPAK.....	87
		PYLERA.....	10, 12, 18, 20, 113	RELTONE.....	117
		<i>pyrazinamide</i> .....	13	RELYVRIO.....	68

RESTASIS.....	103, 142	SENNA LAXATIVE.....	116	SLOW RELEASE IRON.....	40
RESTASIS MULTIDOSE		SENNA PLUS.....	116	SLOW-MAG.....	97
.....	103, 143	SENNA WITH DOCUSATE		SLOWMAG MUSCLE	
RETACRIT.....	34	SODIUM.....	116	RECOVERY.....	97
REVATIO.....	64, 157, 160	SENNA-S.....	116	SMART HEART OMEGA-3... 49	
REYVOW.....	87	SENNA-TIME S.....	116	<i>sodium bicarbonate</i> .....	110
REZLIDHIA.....	22	<i>sennosides</i> .....	116	<i>sodium chloride</i> .....	91, 92, 106
REZUROCK.....	151	<i>sennosides-docusate</i>		<i>sodium citrate-citric acid</i> .....	92
REZVOGLAR KWIKPEN		<i>sodium</i> .....	116	SODIUM FLUORIDE 5000	
.....	134, 136	SENOKOT.....	116	PLUS.....	88
RHOPRESSA.....	102, 108	SENOKOT EXTRA		<i>sodium oxybate</i> .....	87
RIABNI.....	22, 143	STRENGTH.....	116	<i>sodium polystyrene</i>	
RID LICE KILLING.....	173	SENOKOT-S.....	116	<i>sulfonate</i> .....	93, 148
<i>rifabutin</i> .....	13, 19	SENTRY.....	39, 181, 190	<i>sodium,potassium,mag</i>	
<i>rifampin</i> .....	13, 19	SENTRY SENIOR.....	181, 190	<i>sulfates</i> .....	116
<i>riluzole</i> .....	68	SEREVENT DISKUS....	31, 159	SOGROYA.....	137
<i>rimantadine</i> .....	10	SERNIVO.....	168	<i>solifenacin</i> .....	174
RINVOQ.....	145	SEROSTIM.....	137	SOLIQUA 100/33.132, 135, 136	
RIOMET.....	126	SETLAKIN.....	129	SOLO.....	181, 190, 196
RIOMET ER.....	126	<i>sevelamer carbonate</i>		SOOTHE (BISMUTH	
<i>risedronate</i> .....	149, 150	.....	92, 93, 148	SUBSALICYLATE).....	110, 111
RITEFLO AEROCHAMBER..	91	<i>sevelamer hcl</i> .....	93, 148	SOOTHE REGULAR	
<i>rivastigmine</i> .....	29	SF.....	88	STRENGTH.....	110, 112
<i>rivastigmine tartrate</i> .....	29	SF 5000 PLUS.....	88	<i>sotalol</i> .....	28, 50, 51, 56, 57, 62
<i>rizatriptan</i> .....	87	SHAROBEL.....	129	SOTALOL AF	
ROCKLATAN.....	102, 107, 108	SHINGRIX (PF).....	25	.....	28, 50, 51, 56, 57, 62
<i>roflumilast</i> .....	156, 170	SIDEROL.....	39, 190, 192	SOTYKTU.....	170
<i>ropinirole</i> .....	77	SIDESTREAM PEDIATRIC		SOTYLIZE	
<i>rosuvastatin</i> .....	61	FACE MASK.....	91	.....	28, 50, 51, 56, 57, 62
ROXICODONE.....	81	SIKLOS.....	22	SPECTRAVITE ADVANCED	
ROXYBOND.....	82	<i>sildenafil</i>		FORMULA.....	40, 181, 190
RYALTRIS.....	100, 105, 155	( <i>pulm.hypertension</i> )		SPECTRAVITE MEN'S	
RYBELSUS.....	132	.....	64, 157, 160	.....	40, 181, 190
RYTARY.....	76	SILICONE MASK - INFANT..	91	SPEEDYSWAB COVID-19	
SANCUSO.....	108	SILICONE MASK -		HOME TEST.....	91
SAVAYSA.....	33	PEDIATRIC.....	91	SPIKEVAX 2023-2024(12Y	
SAVELLA.....	77, 86	SILIQ.....	169	UP)(PF).....	25
<i>saxagliptin</i> .....	130	<i>silodosin</i> .....	30	<i>spinosad</i> .....	173
<i>saxagliptin-metformin</i> ..	126, 130	<i>silver sulfadiazine</i> .....	171	SPIRIVA RESPIMAT.....	27, 153
SAXENDA.....	132	SIMBRINZA.....	100, 104	SPIRIVA WITH	
SEGLENTIS.....	76, 82	<i>simethicone</i> .....	113	HANDIHALER.....	27, 153
SEGLUROMET.....	126, 140	SIMPONI.....	147	<i>spironolactone</i> .....	63, 64, 65, 93
<i>selegiline hcl</i> .....	77	SIMPONI ARIA.....	147	<i>spironolacton-</i>	
<i>selenium sulfide</i> .....	171	<i>simvastatin</i> .....	61	<i>hydrochlorothiaz</i>	
SEMGLEE(INSULIN		SINEMET.....	76	.....	63, 64, 66, 93, 98
GLARGINE-YFGN).....	135, 136	SINGULAIR.....	154	SPORANOX.....	14
SEMGLEE(INSULIN		<i>sirolimus</i> .....	145, 169	SPRINTEC (28).....	129
GLARG-YFGN)PEN....	135, 136	SIRTURO.....	13	SPRIX.....	85, 107
SE-NATAL-19.....	39, 181, 190	SIVEXTRO.....	18	SRONYX.....	129
SENEXTON-S.....	116	SKYRIZI.....	169, 170	SSD.....	171
SENNA.....	116	SKYTROFA.....	137	STEGLATRO.....	140
SENNA LAX.....	116	SLO-NIACIN.....	49	STEGLUJAN.....	130, 140

STELARA.....	144	SYNALAR OINTMENT KIT .	168	TENORETIC 50	
STIMUFEND.....	34	SYNALAR TS.....	168	.....	32, 50, 51, 56, 66, 99
STIMULANT LAXATIVE		SYNJARDY.....	126, 140	TENORMIN.....	32, 43, 56
PLUS.....	116	SYNJARDY XR.....	126, 140	<i>terazosin</i> .....	29, 43, 62
STIOLTO RESPIMAT		SYNTHROID.....	141	<i>terbinafine hcl</i> .....	10, 160
.....	27, 31, 153, 159	SYSTANE (PROPYLENE		<i>terbutaline</i> .....	31, 159
STOMACH RELIEF.....	110, 112	GLYCOL).....	106	<i>terconazole</i> .....	165
STOMACH RELIEF MAX		SYSTANE GEL.....	106	<i>teriflunomide</i> .....	142
STRENGTH.....	110, 112	SYSTANE ULTRA.....	106	<i>teriparatide</i> .....	136, 149
STOMACH RELIEF		TAB-A-VITE MULTIVITAMIN		TESTIM.....	124
ORIGINAL.....	110, 112	W-IRON.....	40, 181, 190	<i>testosterone</i> .....	124
STOOL SOFTENER.....	117	TABLOID.....	23	<i>testosterone cypionate</i> .....	124
STOOL SOFTENER-		<i>tacrolimus</i> .....	143, 170	TEXACORT.....	168
LAXATIVE.....	117	TACTINAL.....	71	TEZSPIRE.....	154
STOOL SOFTENER-		<i>tadalafil (pulm. hypertension)</i>		THALOMID.....	150
STIMULANT LAXAT.....	117	.....	64, 160	<i>theophylline</i> .....	60, 92, 160, 174
STRESS FORMULA.....	181	TADLIQ.....	64, 160	THERA.....	181, 190
STRESS FORMULA WITH		<i>tafluprost (pf)</i> .....	107	THERAGRAN-M PREMIER	
IRON.....	40, 190, 192, 194	TAKE ACTION.....	129	50 PLUS.....	181, 190
STRESS FORMULA WITH		TALICIA.....	11, 19, 113, 121	THERALOGIX	
IRON(SULF)..	40, 190, 192, 194	TALTZ AUTOINJECTOR.....	144	COMPANION.....	181, 190
STRIVERDI RESPIMAT	31, 159	TALTZ AUTOINJECTOR (2		THERA-M.....	40, 181, 190
<i>sucralfate</i> .....	120	PACK).....	144	THERANATAL.....	40, 181, 190
SULAR.....	53, 58, 59, 62, 67	TALTZ AUTOINJECTOR (3		THERAPEUTIC-M	
<i>sulfacetamide sodium</i> .....	102	PACK).....	144	.....	40, 97, 182, 190
<i>sulfacetamide sodium-sulfur</i>	171	TALTZ SYRINGE.....	144	THERA-TABS.....	182
<i>sulfacetamide-prednisolone</i> .	102	TAMIFLU.....	16	THERATRUM COMPLETE	
<i>sulfamethoxazole-</i>		<i>tamoxifen</i> .....	23, 130	WITH LUTEIN.....	40, 182
<i>trimethoprim</i> .....	19	<i>tamsulosin</i> .....	30	THYQUIDITY.....	141
<i>sulfasalazine</i> .....	19, 113, 143	TAPERDEX.....	124	TIADYL T ER.....	53, 57
SULFATRIM.....	19	TARGRETIN.....	23, 163	TIAZAC.....	53, 57
<i>sulindac</i> .....	85	TARINA FE 1/20 (28).....	129	TIBSOVO.....	23
<i>sumatriptan</i> .....	87	TASCENSO ODT.....	145	TIGLUTIK.....	69
<i>sumatriptan succinate</i> .....	87	TASMAR.....	75	<i>timolol maleate</i>	
<i>sumatriptan-naproxen</i> .....	78, 87	<i>tavaborole</i> .....	172	.....	29, 50, 51, 56, 62, 73, 104
SUNVITE.....	40, 181, 190, 196	<i>tazarotene</i> .....	171	<i>timolol maleate (pf)</i> .....	104
SUPER GINSENG		TAZTIA XT.....	53, 57	TIMOPTIC OCUDOSE (PF)	104
MULTIVITAMIN.....	181	TAZVERIK.....	23	<i>tinidazole</i> .....	12
SUPER MULTIPLE - LOW		TDVAX.....	24	<i>tiotropium bromide</i> .....	27, 153
IRON.....	181, 190	TECFIDERA.....	143	TIROSINT.....	141
SUPER OMEGA-3.....	49	TEKTRUNA.....	64	TIROSINT-SOL.....	141
SUPER QUINTS.....	190	<i>telmisartan</i> .....	44, 46	<i>tizanidine</i> .....	27
SUPER QUINTS B-50.....	190	<i>telmisartan-amlodipine</i>		TOBI.....	10
SUPER THERA VITE M.....	181	.....	44, 46, 53, 58, 59, 67	TOBI PODHALER.....	10
SYMBICORT.....	31, 123	<i>telmisartan-</i>		<i>tobramycin</i> .....	10, 102
SYMJEPI.....	26, 152	<i>hydrochlorothiazid</i>	45, 46, 66, 99	<i>tobramycin in 0.225 % nacl</i> ...	10
SYMLINPEN 120.....	124	<i>temozolomide</i> .....	23	<i>tobramycin with nebulizer</i> .....	11
SYMLINPEN 60.....	124	TENCON.....	71, 74	<i>tobramycin-dexamethasone</i>	
SYMPROIC.....	119	TENIVAC (PF).....	24	.....	102, 105
SYNAGIS.....	16	TENORETIC 100		<i>tolcapone</i> .....	75
SYNALAR.....	168	.....	32, 50, 51, 56, 66, 99	TOLECTIN 600.....	78
SYNALAR CREAM KIT.....	168			<i>tolnaftate</i> .....	174



TOLSURA.....	14	TRI-LINYAH.....	129	UBRELVY.....	75
<i>tolterodine</i> .....	174	TRILIPIX.....	60	UCERIS.....	124
TOPICORT.....	168	TRI-LO-MARZIA.....	129	UDENYCA.....	34
TOPROL XL.....	32, 50, 51, 56	TRI-LO-SPRINTEC.....	129	UDENYCA	
<i>toremifene</i> .....	23, 130	<i>trimethoprim</i> .....	20	AUTOINJECTOR.....	34
<i>toremide</i> .....	63, 92	TRINATAL RX 1		ULORIC.....	149
TOSYMRA.....	87	.....	40, 97, 182, 190	ULTRA FREEDA	
TOUJEO MAX U-300		TRIPHROCAPS.....	190, 192	.....	40, 97, 182, 191
SOLOSTAR.....	135, 136	TRIPLE ANTIBIOTIC.....	162	ULTRA STRENGTH	
TOUJEO SOLOSTAR U-300		TRI-SPRINTEC (28).....	129	ANTACID.....	97, 111
INSULIN.....	135, 136	TRI-VI-SOL..	182, 183, 192, 194	ULTRAVATE.....	169
TOVET EMOLLIENT.....	168	TRI-VITAMIN WITH		UNITHROID.....	141
TOVET KIT.....	168	FLUORIDE		UPTRAVI.....	68, 160
TOVIAZ.....	174	.....	150, 182, 183, 192, 194	URO-MAG.....	111
TRACLEER.....	67, 160	TRIVORA (28).....	129	URSO 250.....	117
TRADJENTA.....	130	TRI-VYLIBRA LO.....	129	URSO FORTE.....	117
<i>tramadol</i> .....	82	<i>tropicamide</i> .....	107	<i>ursodiol</i> .....	117
<i>tramadol-acetaminophen</i>		<i>trospium</i> .....	174	VAGIFEM.....	131
.....	71, 73, 82	TRULANCE.....	118	<i>valacyclovir</i> .....	17
<i>trandolapril</i> .....	47, 48	TRULICITY.....	132	<i>valganciclovir</i> .....	17
<i>trandolapril-verapamil</i>		TRUMENBA.....	25	<i>valsartan</i> .....	45, 46
.....	47, 48, 52, 53, 54, 67	TRUSTEX LATEX		<i>valsartan-</i>	
TRAVATAN Z.....	107	CONDOM.....	151	<i>hydrochlorothiazide</i>	
<i>travoprost</i> .....	107	TRUSTEX LUBRICATED		.....	45, 46, 66, 99
TRECTOR.....	13	CONDOMS.....	151	VALTREX.....	17
TRELEGY ELLIPTA		TRUSTEX NON-LUB		VANCOGIN.....	15
.....	153, 156, 159	CONDOMS.....	151	<i>vancomycin</i> .....	15
TREMFYA.....	143, 170	TRUSTEX-RIA		VANDAZOLE.....	16
TRESIBA FLEXTOUCH U-		LUB/SPERMICIDE.....	152	VANOS.....	169
100.....	135, 136	TRUSTEX-RIA NON-LUB		VAQTA (PF).....	25
TRESIBA FLEXTOUCH U-		CONDOMS.....	152	<i>varenicline</i> .....	32
200.....	135, 136	TRUZONE PEAK FLOW		VARIVAX (PF).....	25
TRESIBA U-100 INSULIN		METER.....	91	VASCEPA.....	63
.....	135, 136	TUDORZA PRESSAIR..	27, 153	VASERETIC.....	47, 48, 66, 99
<i>tretinoin</i> .....	166	TUMS.....	97, 110	VASOTEC.....	47, 48
<i>tretinoin (antineoplastic)</i> .....	23	TUMS E-X.....	97, 110	VAXNEUVANCE (PF).....	25
TREXIMET.....	78, 87	TUMS EXTRA STRENGTH		V-C FORTE.....	182, 191
<i>triamcinolone acetonide</i>		SMOOTHIES.....	97, 110	VEGETABLE LAXATIVE.....	117
.....	105, 155, 168, 169	TUMS FRESHERS.....	97, 110	VELIVET TRIPHASIC	
<i>triamterene-</i>		TUMS ULTRA.....	97, 111	REGIMEN (28).....	129
<i>hydrochlorothiazid</i>	64, 66, 93, 99	TWINRIX (PF).....	25	VELPHORO.....	93
TRIANEX.....	169	TYLENOL.....	71	VELSIPITY.....	118, 150
TRIBENZOR		TYLENOL EXTRA		VEMLIDY.....	17
.....	45, 46, 53, 58, 59, 66, 99	STRENGTH.....	71	VENCLEXTA.....	23
TRI-BUFFERED ASPIRIN		TYMLOS.....	136, 149	VENCLEXTA STARTING	
.....	42, 73, 86	TYRVAYA.....	27	PACK.....	23
TRICARE.....	40, 182, 190	TYVASO.....	67, 160	VENTAVIS.....	157
TRICOR.....	60	TYVASO DPI.....	68, 160	VENTOLIN HFA.....	31, 159
TRIDERM.....	169	TYVASO INSTITUTIONAL		<i>verapamil</i> .....	53, 57
TRI-ESTARYLLA.....	129	START KIT.....	68, 160	VERELAN PM.....	54, 57
TRIJARDY XR.....	126, 130, 140	TYVASO REFILL KIT....	68, 160	VERQUVO.....	55
TRI-LEGEST FE.....	129	TYVASO STARTER KIT	68, 160	VESICARE.....	174

VESICARE LS.....	174	VYTORIN 10-40.....	55, 61	XATMEP.....	23, 143
VESTURA (28).....	129	VYTORIN 10-80.....	55, 61	XELJANZ.....	145
VFEND.....	14	VYZULTA.....	107	XELJANZ XR.....	145
VIBERZI.....	112	WAL-FINATE.....	7, 154	XELPROS.....	108
VIC-FORTE.....	182, 191	WAL-MUCIL FIBER		XENICAL.....	118
VICTOZA 2-PAK.....	132	(ASPARTAME).....	117	XEPI.....	162
VICTOZA 3-PAK.....	132	WAL-MUCIL FIBER		XERESE.....	17, 163, 169
VIGAMOX.....	102, 162	(SUGAR).....	117	XHANCE.....	105, 155
VIMOVO.....	78, 121	<i>warfarin</i> .....	33	XIFAXAN.....	19
VIOKACE.....	117	WEGOVI.....	132	XIGDUO XR.....	126, 140
VIRT-CAPS.....	191, 192	WELCHOL.....	52, 125	XIIDRA.....	103
VISTARIL.....	7, 74	WERA (28).....	129	XOFLUZA.....	14
VITACEL (WITH LUTEIN)		WESCAPS.....	191, 192	XOLAIR.....	144
.....	182, 191	WESTAB MAX.....	191	XOPENEX HFA.....	31, 159
VITAL-D RX.....	191, 192, 194	WESTAB PLUS		XPOVIO.....	23
VITALEE.....	182, 191	.....	40, 97, 182, 191	XTAMPZA ER.....	82
<i>vitamin a palmitate</i> .....	183	<i>wheat germ oil</i> .....	195	XTANDI.....	23
<i>vitamin b complex</i> .....	191	WIDE-SEAL DIAPHRAGM		XULANE.....	129
<i>vitamin b complex-folic acid</i> .....	191	60.....	152	XULTOPHY 100/3.6	
VITAMIN D2.....	194	WIDE-SEAL DIAPHRAGM		.....	132, 135, 136
VITAMIN D3.....	194	65.....	152	XYWAV.....	88
<i>vitamin e</i> .....	195	WIDE-SEAL DIAPHRAGM		YELETS.....	40, 182, 191
<i>vitamin e (dl, acetate)</i> .....	194	70.....	152	YOSPRALA.....	42, 86, 121
<i>vitamin e acetate</i> .....	195	WIDE-SEAL DIAPHRAGM		YUFLYMA(CF).....	147
<i>vitamin e mixed</i> .....	195	75.....	152	YUFLYMA(CF)	
<i>vitamin e succinate</i> .....	195	WIDE-SEAL DIAPHRAGM		AUTOINJECTOR.....	147
VITAMINS A,C,D AND		80.....	152	YUPELRI.....	27
FLUORIDE		WIDE-SEAL DIAPHRAGM		YUSIMRY(CF) PEN.....	147
.....	150, 182, 183, 192, 194	85.....	152	YUVAFEM.....	131
VITAMINS A-D-E		WIDE-SEAL DIAPHRAGM		ZADITOR.....	100
SELENIUM..	182, 183, 194, 195	90.....	152	ZAFEMY.....	129
VITAMINS B COMPLEX.....	191	WIDE-SEAL DIAPHRAGM		<i>zafirlukast</i> .....	154
VITA-RESPA.....	191	95.....	152	ZANAFLEX.....	27
VITATRUM.....	182	WIXELA INHUB.....	31, 124	ZARAH.....	129
VITRUM SENIOR.....	182, 191	WOMAN'S LAXATIVE		ZARXIO.....	35
VOGELXO.....	124	(BISACODYL).....	117	ZAVZPRET.....	75
<i>voriconazole</i> .....	14	WOMEN'S DAILY		ZEGALOGUE	
VORTEX ADULT MASK.....	91	FORMULA.....	40, 182	AUTOINJECTOR.....	132
VORTEX HOLDING		WOMEN'S GENTLE		ZEGALOGUE SYRINGE.....	132
CHAMBER.....	91	LAXATIVE(BISAC).....	117	ZEGERID.....	121
VORTEX VHC FROG		WOMEN'S LAXATIVE		ZELAPAR.....	77
MASK-CHILD.....	91	(BISACODYL).....	117	ZEMBRACE SYMTOUCH.....	87
VORTEX VHC LADYBUG		WOMEN'S MULTIVITAMIN		ZENATANE.....	171
MASK-TODDLR.....	91	GUMMIES.....	182, 191	ZENPEP.....	117
VTAMA.....	165	WOMEN'S ONE DAILY		ZEPBOUND.....	132
VUMERITY.....	143	.....	40, 97, 182, 191	ZEPOSIA.....	145
VUSION.....	165	XACIATO.....	15, 162	ZEPOSIA STARTER KIT	
VYFEMLA (28).....	129	XADAGO.....	77	(28-DAY).....	145
VYNDAMAX.....	54	XALATAN.....	108	ZEPOSIA STARTER PACK	
VYNDAQEL.....	54	XARELTO.....	33	(7-DAY).....	146
VYTORIN 10-10.....	55, 61	XARELTO DVT-PE TREAT		ZERVIAE.....	100
VYTORIN 10-20.....	55, 61	30D START.....	33	ZESTORETIC.....	47, 48, 66, 99

ZESTRIL.....	47, 48
ZETIA.....	55
ZETONNA.....	105, 124, 155
ZIEXTENZO.....	35
<i>zileuton</i> .....	154
ZIMHI.....	82, 148
<i>zinc gluconate</i> .....	97
<i>zinc sulfate</i> .....	97
ZINC-220.....	98
ZIOPTAN (PF).....	108
ZIPSOR.....	73, 85, 172
ZITHROMAX.....	17, 18
ZITHROMAX TRI-PAK.....	18
ZITHROMAX Z-PAK.....	18
ZOCOR.....	61
ZOLINZA.....	23
<i>zolmitriptan</i> .....	87
ZOMACTON.....	137
ZOMIG.....	87
ZORVOLEX.....	73, 85, 172
ZORYVE.....	156, 170
ZOVIRAX.....	17, 163, 164
ZYFLO.....	155
ZYLOPRIM.....	149
ZYPITAMAG.....	61
ZYTIGA.....	23
ZYVOX.....	18