

Tufts Medicare Preferred HMO 2014 Formulary



PLEASE READ: This document contains information about the drugs we cover in this plan

This formulary was updated on January 1, 2014. For more recent information or other questions, please contact Tufts Medicare Preferred HMO Customer Relations at 1-800-701-9000 or, for TTY users, 1-800-208-9562, Monday - Friday 8:00 a.m. - 8:00 p.m. (from Oct. 1 - Feb. 14 representatives are available 7 days a week, 8:00 a.m. - 8:00 p.m.). After hours and on holidays, please leave a message and a representative will return your call on the next business day. Or visit tuftsmedicarepreferred.org.

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

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TUFTS MEDICARE PREFERRED HMO

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2014 Formulary (List of Covered Drugs)

When this drug list (formulary) refers to “we,” “us”, or “our,” it means Tufts Medicare Preferred HMO. When it refers to “plan” or “our plan,” it means Tufts Health Plan Medicare Preferred.

This document includes a list of the drugs (formulary) for our plan which is current as of January 1, 2014. For an updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, premium and/or copayments/coinsurance may change on January 1, 2015.

What is the Tufts Medicare Preferred HMO Formulary?

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

Can the Formulary (drug list) change?

Generally, if you are taking a drug on our 2014 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2014 coverage year except when a new, less expensive generic drug becomes available or when new adverse information about the safety or effectiveness of a drug is released. Other types of formulary changes, such as removing a drug from our formulary, will not affect members who are currently taking the drug. It will remain available at the same cost-sharing for those members taking it for the remainder of the coverage year. We feel it is important that you have continued access for the remainder of the coverage year to the formulary drugs that were available when you chose our plan, except for cases in which you can save additional money or we can ensure your safety.

If we remove drugs from our formulary, or add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 60 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 60-day supply of the drug. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug’s manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug. The enclosed formulary is current as of January 1, 2014. To get updated information about the drugs covered by Tufts Medicare Preferred HMO, please contact us. Our contact information appears on the front and back cover pages.

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 2. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, “Cardiovascular Agents”. If you know what your drug is used for, look for the category name in the list that begins on page 2. Then look under the category name for your drug.

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 67. The Index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

Tufts Medicare Preferred HMO covers both brand name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand name drug. Generally, generic drugs cost less than brand name drugs.

Are there any restrictions on my coverage?

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

- **Prior Authorization:** Tufts Medicare Preferred HMO requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from Tufts Medicare Preferred HMO before you fill your prescriptions. If you don't get approval, Tufts Medicare Preferred HMO may not cover the drug.
- **Quantity Limits:** For certain drugs, Tufts Medicare Preferred HMO limits the amount of the drug that Tufts Medicare Preferred HMO will cover. For example, Tufts Medicare Preferred HMO provides 30 tablets per prescription for *zolpidem*. This may be in addition to a standard one-month or three-month supply.
- **Step Therapy:** In some cases, Tufts Medicare Preferred HMO requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, Tufts Medicare Preferred HMO may not cover Drug B unless you try Drug A first. If Drug A does not work for you, Tufts Medicare Preferred HMO will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 2. You can also get more information about the restrictions applied to specific covered drugs by visiting our Web site. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask Tufts Medicare Preferred HMO to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, “How do I request an exception to the Tufts Medicare Preferred HMO formulary?” below for information about how to request an exception.

What if my drug is not on the Formulary?

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

If you learn that Tufts Medicare Preferred HMO does not cover your drug, you have two options:

- You can ask Customer Relations for a list of similar drugs that are covered by Tufts Medicare Preferred HMO. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by Tufts Medicare Preferred HMO.
- You can ask Tufts Medicare Preferred HMO to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the Tufts Medicare Preferred HMO Formulary?

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

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

Generally, Tufts Medicare Preferred HMO will only approve your request for an exception if the alternative drugs included on the plan’s formulary, the lower cost-sharing drug or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary, tiering or utilization restriction exception. **When you request a formulary, tiering or utilization restriction exception you should submit a statement from your prescriber or physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescriber’s supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get a supporting statement from your doctor or other prescriber.

What do I do before I can talk to my doctor about changing my drugs or requesting an exception?

As a new or continuing member in our plan you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 30-day supply (unless you have a prescription written for fewer days) when you go to a network pharmacy. After your first 30-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility, we will allow you to refill your prescription until we have provided you with a 93-day transition supply, consistent with dispensing increment, (unless you have a prescription written for fewer days). We will cover more than one refill of these drugs for the first 90 days you are a member of our plan. If you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug (unless you have a prescription for fewer days) while you pursue a formulary exception.

As a current member, if you are admitted to or discharged from a long term facility and experience an unplanned drug change, you can request that we approve a one-time, temporary fill of the non-covered medication to allow you time to discuss a transition plan with your physician. Your physician can also request an exception to coverage for the non-covered drug based on review for medical necessity following the standard exception process outlined previously. The temporary “first fill” will generally be up to a 31-day supply, but may be extended to allow you and your physician time to manage the complexities of multiple medications or when special circumstances warrant. You can request a temporary prescription fill by calling the Tufts Health Plan Medicare Preferred HMO Customer Relations department.

For more information

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

If you have questions about Tufts Medicare Preferred HMO, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

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

Tufts Medicare Preferred HMO's Formulary

The formulary that begins on page 2 provides coverage information about some of the drugs covered by Tufts Medicare Preferred HMO. If you have trouble finding your drug in the list, turn to the Index that begins on page 67.

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

The information in the Requirements/Limits column tells you if Tufts Medicare Preferred HMO has any special requirements for coverage of your drug.

B/D: Medicare Part B or D

These drugs require prior authorization to determine appropriate coverage under Medicare Part B or Part D.

QL: Quantity Limit Applies.

Because of potential safety and utilization concerns, Tufts Medicare Preferred HMO has placed dispensing limitations on a small number of prescription drugs. This means that the pharmacy will only dispense a certain quantity of a drug within a given time period. These quantities are based on recognized standards of care, such as U.S. Food and Drug Administration recommendations for use. If your doctor believes you need a quantity greater than the program limitation, your doctor can submit a request for coverage under the Medical Review Process. The Medical Review Process allows you or your doctor to ask Tufts Medicare Preferred HMO to make an exception to our coverage rules. See the section, "How do I request an exception to the Tufts Medicare Preferred HMO formulary?" on page III for information about how to request an exception.

HI: Home Infusion Drug.

This prescription drug may be covered under your Medicare Part B benefit. Home Infusion drugs that are not covered under Medicare Part B will be covered under Medicare Part D. For more information, call Customer Relations at 1-800-701-9000, Monday-Friday 8:00 a.m. – 8:00 p.m. (From Oct. 1 –Feb. 14 representatives are available 7 days a week, 8:00 a.m. - 8:00 p.m.). After hours and on holidays, please leave a message and a representative will return your call on the next business day. TTY users should call 1-800-208-9562.

LA: Limited Access Drug.

This prescription may be available only at certain pharmacies. For more information consult your Pharmacy Directory or call Customer Relations at 1-800-701-9000, Monday-Friday 8:00 a.m. – 8:00 p.m. (From Oct. 1 –Feb. 14 representatives are available 7 days a week, 8:00 a.m. - 8:00 p.m.). After hours and on holidays, please leave a message and a representative will return your call the on next business day. TTY users should call 1-800-208-9562.

PA: Prior Authorization Required.

The Prior Authorization process encourages rational prescribing of drug products with significant safety and/or financial concerns. A provider can submit a request for coverage based on a member’s medical need for a particular drug. If approved, the member pays the designated tier co-payment. An appeal process exists for denied requests.

STPA: Step Therapy Prior Authorization Applies.

Step Therapy is an automated form of Prior Authorization, which uses claims history for approval of a drug at the point of sale. Step Therapy Programs help encourage the clinically proven use of first-line therapies and are designed to ensure the utilization of the most therapeutically appropriate and cost-effective agents first, before other treatments may be covered.

Members who are currently on drugs that meet the initial Step Therapy criteria will automatically be able to fill their prescriptions for a stepped medication. If the member does not meet the initial Step Therapy criteria, the prescription will deny at the point of sale with a message indicating that Prior Authorization (PA) is required. Physicians may submit Prior Authorization requests to Tufts Medicare Preferred HMO for members who do not meet the Step Therapy criteria at the point of sale under the Medical Review process. The Medical Review Process allows you or your doctor to ask Tufts Medicare Preferred HMO to make an exception to our coverage rules. See the section, “How do I request an exception to the Tufts Medicare Preferred HMO formulary?” on page III for information about how to request an exception.

Transplant:

This drug is covered under Part B when used for a Medicare covered organ transplant.

Coverage Gap:

For Tufts Medicare Preferred HMO Prime Rx Plus members, we provide coverage for Tier 1 and Tier 2 drugs in the Coverage Gap. Please refer to our Evidence of Coverage for more information about this coverage.

***Part B Drug:**

No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Your Prescription Drug Costs

	HMO Saver RX Barnstable, Bristol, Essex, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester counties		HMO Basic RX HMO Value RX HMO Prime RX Barnstable, Bristol, Essex, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, and Suffolk counties		HMO Prime RX Plus Barnstable, Bristol, Essex, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, and Suffolk counties		HMO Basic RX HMO Value RX HMO Prime RX Worcester county	
Copays	Retail 30-day supply	Mail order 90-day supply	Retail 30-day supply	Mail order 90-day supply	Retail 30-day supply	Mail order 90-day supply	Retail 30-day supply	Mail order 90-day supply
Tier 1	\$5	\$12	\$5	\$12	\$2	\$5	\$4	\$10
Tier 2	\$10	\$24	\$10	\$ 24	\$5	\$12	\$6	\$15
Tier 3	\$45	\$135	\$35	\$105	\$30	\$90	\$25	\$75
Tier 4	\$95	\$285	\$93	\$279	\$75	\$225	\$55	\$165
Tier 5	33%	33%	33%	33%	33%	33%	33%	33%
Coverage Gap Stage								
After your total prescription drug costs reach \$2,850, and until your payments reach \$4,550, you pay:								
	<ul style="list-style-type: none"> • 72% of costs for Part D generic drugs • 47.5% of costs for Part D brand drugs 	<ul style="list-style-type: none"> • 72% of costs for Part D generic drugs • 47.5% of costs for Part D brand drugs 	<ul style="list-style-type: none"> • Tier 1 copayments for generic drugs on tier 1 • Tier 2 copayments for generic drugs on tier 2 • 72% of costs for All other Part D generic drugs • 47.5% of costs for Part D brand drugs 	<ul style="list-style-type: none"> • 72% of costs for Part D generic drugs • 47.5% of costs for Part D brand drugs 				
Catastrophic Coverage Stage								
After the coverage gap, when your payments for the year are greater than \$4,550, you pay the greater of:								
	5% per prescription , or \$2.55 per prescription for Part D generic drugs, \$6.35 per prescription for Part D brand drugs							

**2014 Tufts Medicare Preferred Formulary
HMO Individual Members**

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**2014 Tufts Medicare Preferred Formulary
HMO Individual Members**

Drug Name	Drug Tier	Requirements/Limits
ANTI-INFECTIVES AND INFECTIOUS DISEASE		
ANTIFUNGALS, SYSTEMIC AND ORAL TOPICAL		
ANCOBON	Tier-4	
<i>clotrimazole mucous membrane</i>	Tier-2	
<i>fluconazole oral suspension for reconstitution</i>	Tier-2	
<i>fluconazole oral tablet 100 mg, 200 mg, 50 mg</i>	Tier-1	
<i>flucytosine</i>	Tier-2	
GRIS-PEG (ULTRAMICROSIZED)	Tier-3	
<i>griseofulvin microsize</i>	Tier-2	
<i>griseofulvin ultramicrosize</i>	Tier-2	
<i>itraconazole</i>	Tier-2	PA
<i>ketoconazole oral</i>	Tier-2	
<i>ketoconazole topical foam</i>	Tier-2	
LAMISIL ORAL GRANULES IN PACKET 125 MG	Tier-4	QL (56 EA per 30 days)
LAMISIL ORAL GRANULES IN PACKET 187.5 MG	Tier-4	QL (28 EA per 30 days)
NAFTIN	Tier-3	
NOXAFIL ORAL	Tier-4	
<i>nystatin oral tablet</i>	Tier-2	
<i>terbinafine hcl oral</i>	Tier-1	QL (42 EA per 42 days)
VFEND ORAL SUSPENSION FOR RECONSTITUTION	Tier-5	
<i>voriconazole oral suspension for reconstitution</i>	Tier-2	
<i>voriconazole oral tablet 200 mg</i>	Tier-2	QL (28 EA per 14 days)
<i>voriconazole oral tablet 50 mg</i>	Tier-2	QL (56 EA per 14 days)
ANTI-INFECTIVES, MISCELLANEOUS		
ALBENZA	Tier-3	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
ALINIA	Tier-4	
BILTRICIDE	Tier-3	
<i>methenamine hippurate</i>	Tier-2	
<i>metronidazole oral</i>	Tier-2	
MONUROL	Tier-4	
<i>neomycin</i>	Tier-2	
PRIMSOL	Tier-3	
STROMECTOL	Tier-3	
<i>trimethoprim</i>	Tier-2	
VANCOGIN	Tier-5	
<i>vancomycin oral capsule</i>	Tier-2	
XIFAXAN ORAL TABLET 200 MG	Tier-4	QL (9 EA per 30 days)
XIFAXAN ORAL TABLET 550 MG	Tier-4	PA; QL (60 EA per 30 days)
ZYVOX ORAL	Tier-5	
ANTIMALARIALS AND ANTIPROTOZOALS		
<i>atovaquone</i>	Tier-2	
<i>atovaquone-proguanil</i>	Tier-2	
<i>chloroquine phosphate oral</i>	Tier-2	
COARTEM	Tier-3	QL (24 EA per 30 days)
<i>dapsone</i>	Tier-2	
DARAPRIM	Tier-3	
<i>hydroxychloroquine oral</i>	Tier-2	
<i>mefloquine</i>	Tier-2	
MEPRON	Tier-3	
NEBUPENT	Tier-4	
<i>paromomycin</i>	Tier-2	
PENTAM	Tier-3	
<i>primaquine</i>	Tier-2	
<i>quinine sulfate</i>	Tier-2	
<i>tinidazole</i>	Tier-2	
ANTIVIRALS		
<i>abacavir</i>	Tier-2	
<i>abacavir-lamivudine-zidovudine</i>	Tier-2	
<i>acyclovir oral capsule</i>	Tier-1	
<i>acyclovir oral suspension 200 mg/5 ml</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
<i>acyclovir oral tablet</i>	Tier-2	
<i>adefovir</i>	Tier-2	
<i>amantadine hcl oral</i>	Tier-2	
APTIVUS	Tier-3	
ATRIPLA	Tier-5	
BARACLUDE	Tier-3	
COMPLERA	Tier-5	
COPEGUS	Tier-5	
CRIXIVAN ORAL CAPSULE 200 MG, 400 MG	Tier-3	
<i>didanosine</i>	Tier-2	
EDURANT	Tier-3	
EMTRIVA	Tier-3	
EPIVIR ORAL SOLUTION	Tier-3	
EPIVIR HBV	Tier-3	
EPZICOM	Tier-3	
<i>famciclovir</i>	Tier-2	
FUZEON SUBCUTANEOUS RECON SOLN	Tier-5	
HEPSERA	Tier-5	
INCIVEK	Tier-5	PA
INTELENCE	Tier-3	
INTRON A INJECTION RECON SOLN 10 MILLION UNIT (1 ML)	Tier-3	
INTRON A INJECTION SOLUTION 6 MILLION UNIT/ML	Tier-3	
INTRON A SUBCUTANEOUS	Tier-3	
INVIRASE	Tier-3	
ISENTRESS ORAL POWDER IN PACKET	Tier-5	QL (180 EA per 30 days)
ISENTRESS ORAL TABLET	Tier-5	QL (360 EA per 90 days)
ISENTRESS ORAL TABLET,CHEWABLE 100 MG	Tier-5	QL (180 EA per 30 days)
ISENTRESS ORAL TABLET,CHEWABLE 25 MG	Tier-5	QL (720 EA per 30 days)
KALETRA	Tier-3	
<i>lamivudine</i>	Tier-2	
<i>lamivudine-zidovudine</i>	Tier-2	
LEXIVA	Tier-3	
MODERIBA	Tier-5	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
MODERIBA DOSE PACK ORAL TABLETS,DOSE PACK 400 MG (7)- 400 MG (7), 600 MG (7)- 600 MG (7)	Tier-5	
<i>nevirapine</i>	Tier-2	
NORVIR	Tier-3	
OLYSIO	Tier-5	PA
PEGASYS SUBCUTANEOUS SOLUTION	Tier-5	PA; QL (4 ML per 28 Days)
PEGASYS SUBCUTANEOUS SYRINGE	Tier-5	PA; QL (4 ML per 30 Days)
PEGASYS PROCLICK SUBCUTANEOUS PEN INJECTOR 135 MCG/0.5 ML	Tier-5	PA; QL (4 ML per 30 days)
PEGINTRON SUBCUTANEOUS KIT 120 MCG/0.5 ML, 150 MCG/0.5 ML, 80 MCG/0.5 ML	Tier-5	PA; QL (4 EA per 30 days)
PEGINTRON SUBCUTANEOUS KIT 50 MCG/0.5 ML	Tier-5	PA; QL (8 EA per 30 days)
PEGINTRON REDIPEN	Tier-5	PA; QL (4 EA per 30 days)
PREZISTA ORAL SUSPENSION	Tier-3	
PREZISTA ORAL TABLET 150 MG, 600 MG, 75 MG, 800 MG	Tier-3	
REBETOL ORAL SOLUTION	Tier-3	
RELENZA DISKHALER	Tier-3	QL (60 EA per 180 days)
RESCRIPTOR	Tier-3	
REYATAZ	Tier-3	
<i>ribapak dose pack oral tablets,dose pack 400-400 mg (28)-mg (28), 600-400 mg (28)-mg (28), 600-600 mg (28)-mg (28)</i>	Tier-5	
<i>ribasphere</i>	Tier-2	
<i>ribavirin oral capsule</i>	Tier-2	
<i>ribavirin oral tablet 200 mg</i>	Tier-2	
<i>rimantadine</i>	Tier-2	
SELZENTRY ORAL TABLET 150 MG	Tier-5	QL (60 EA per 30 days)
SELZENTRY ORAL TABLET 300 MG	Tier-5	QL (120 EA per 30 days)
SOVALDI	Tier-5	PA
<i>stavudine</i>	Tier-2	
STRIBILD	Tier-3	
SUSTIVA	Tier-3	
TAMIFLU ORAL CAPSULE 30 MG	Tier-3	QL (56 EA per 180 days)
TAMIFLU ORAL CAPSULE 45 MG, 75 MG	Tier-3	QL (28 EA per 180 days)

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
TAMIFLU ORAL SUSPENSION FOR RECONSTITUTION 6 MG/ML	Tier-3	QL (360 ML per 180 days)
TIVICAY	Tier-5	
TRIZIVIR	Tier-3	
TRUVADA	Tier-3	
TYZEKA	Tier-3	QL (30 EA per 30 days)
<i>valacyclovir</i>	Tier-3	
VALCYTE	Tier-5	
VICTRELIS	Tier-5	PA
VIDEX 2 GRAM PEDIATRIC	Tier-3	
VIRACEPT ORAL TABLET	Tier-3	
VIRAMUNE ORAL SUSPENSION	Tier-3	
VIRAMUNE XR	Tier-3	
VIREAD	Tier-3	
ZERIT ORAL RECON SOLN	Tier-4	
ZIAGEN	Tier-3	
<i>zidovudine</i>	Tier-2	
BETA-LACTAM ANTIBIOTICS		
<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</i>	Tier-2	
<i>ampicillin oral capsule</i>	Tier-1	
<i>ampicillin oral suspension for reconstitution</i>	Tier-2	
BICILLIN C-R	Tier-3	
BICILLIN L-A	Tier-3	
CEDAX	Tier-4	
<i>cefaclor oral capsule</i>	Tier-2	
<i>cefaclor oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml, 375 mg/5 ml</i>	Tier-2	
<i>cefaclor oral tablet extended release 12 hr</i>	Tier-2	
<i>cefadroxil oral capsule</i>	Tier-2	
<i>cefadroxil oral suspension for reconstitution 250 mg/5 ml, 500 mg/5 ml</i>	Tier-2	
<i>cefadroxil oral tablet</i>	Tier-2	
<i>cefdinir</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
<i>cefpodoxime</i>	Tier-2	
<i>cefprozil</i>	Tier-2	
<i>cefuroxime axetil oral tablet</i>	Tier-2	
<i>cephalexin oral capsule 250 mg, 500 mg</i>	Tier-2	
<i>cephalexin oral suspension for reconstitution</i>	Tier-2	
<i>cephalexin oral tablet</i>	Tier-2	
<i>dicloxacillin</i>	Tier-2	
<i>penicillin v potassium</i>	Tier-1	
SPECTRACEF ORAL TABLET 400 MG	Tier-4	
SUPRAX	Tier-4	
KETOLIDES		
KETEK	Tier-3	
MACROLIDES AND CLINDAMYCIN		
<i>azithromycin oral</i>	Tier-2	
<i>clarithromycin</i>	Tier-2	
<i>clindamycin hcl</i>	Tier-2	
<i>clindamycin pediatric</i>	Tier-2	
DIFICID	Tier-5	PA
<i>e.e.s. 400 oral tablet</i>	Tier-2	
E.E.S. GRANULES	Tier-4	
ERY-TAB	Tier-4	
<i>eryped 200</i>	Tier-2	
<i>eryped 400</i>	Tier-2	
<i>erythrocin (as stearate) oral tablet 250 mg</i>	Tier-2	
<i>erythromycin oral tablet</i>	Tier-2	
<i>erythromycin ethylsuccinate oral tablet</i>	Tier-2	
PCE	Tier-4	
ZMAX	Tier-4	
MYCOBACTERIAL INFECTIONS-TUBERCULOSIS AND MYCOBACTERIUM AVIUM COMPLEX		
<i>ethambutol</i>	Tier-2	
<i>isoniazid oral solution</i>	Tier-2	
<i>isoniazid oral tablet</i>	Tier-1	
MYCOBUTIN	Tier-3	
PASER	Tier-4	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
PRIFTIN	Tier-3	
<i>pyrazinamide</i>	Tier-2	
<i>rifabutin</i>	Tier-2	
RIFAMATE	Tier-4	
<i>rifampin intravenous</i>	Tier-2	
<i>rifampin oral</i>	Tier-2	
RIFATER	Tier-4	
SEROMYCIN	Tier-3	
SIRTURO	Tier-3	PA
TRECTOR	Tier-4	
QUINOLONES		
CIPRO ORAL SUSPENSION,MICROCAPSULE RECON	Tier-4	
CIPRO XR	Tier-4	
<i>ciprofloxacin oral suspension,microcapsule recon</i>	Tier-2	
<i>ciprofloxacin oral tablet</i>	Tier-1	
<i>ciprofloxacin (mixture)</i>	Tier-2	
FACTIVE	Tier-4	
<i>levofloxacin oral</i>	Tier-3	
<i>moxifloxacin</i>	Tier-3	
NOROXIN	Tier-4	
<i>ofloxacin oral</i>	Tier-2	
SULFONAMIDES		
<i>sulfadiazine oral</i>	Tier-2	
<i>sulfamethoxazole-trimethoprim oral suspension</i>	Tier-2	
<i>sulfamethoxazole-trimethoprim oral tablet</i>	Tier-1	
TETRACYCLINES		
<i>demeclocycline oral</i>	Tier-2	
<i>doxycycline hyclate oral capsule</i>	Tier-1	
<i>doxycycline hyclate oral tablet 100 mg</i>	Tier-1	
<i>doxycycline hyclate oral tablet,delayed release (dr/ec)</i>	Tier-1	
<i>doxycycline monohydrate oral capsule 75 mg</i>	Tier-1	
<i>doxycycline monohydrate oral suspension for reconstitution</i>	Tier-2	
<i>doxycycline monohydrate oral tablet 150 mg, 50 mg, 75 mg</i>	Tier-1	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
<i>minocycline oral</i>	Tier-2	
<i>tetracycline</i>	Tier-1	
VIBRAMYCIN ORAL SYRUP	Tier-4	
BLOOD THINNERS AND BLOOD MODIFYING AGENTS		
ANTIPLATELET THERAPY		
AGGRENEX	Tier-4	
<i>clopidogrel</i>	Tier-2	
<i>dipyridamole oral</i>	Tier-2	
EFFIENT	Tier-4	
BLOOD MODIFYING AGENTS		
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 300 MCG/ML, 40 MCG/ML, 60 MCG/ML	Tier-3	QL (4 ML per 30 days)
ARANESP (IN POLYSORBATE) INJECTION SYRINGE	Tier-3	QL (4 ML per 30 days)
EPOGEN INJECTION SOLUTION 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	Tier-3	QL (10 ML per 14 days)
GRANIX	Tier-5	QL (10 ML per 14 Days)
LEUKINE	Tier-5	
MOZOBIL	Tier-3	PA
NEULASTA	Tier-5	QL (1 ML per 14 days)
NEUMEGA	Tier-5	
NEUPOGEN INJECTION SOLUTION 480 MCG/1.6 ML	Tier-5	QL (10 ML per 14 days)
NEUPOGEN INJECTION SYRINGE	Tier-5	QL (10 ML per 14 days)
PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML, 40,000 UNIT/ML	Tier-3	QL (10 ML per 14 days)
PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG	Tier-5	PA; QL (30 EA per 30 days)
PROMACTA ORAL TABLET 75 MG	Tier-5	PA; QL (60 EA per 30 days)
BLOOD THINNERS		
BRILINTA	Tier-4	
COUMADIN	Tier-4	
ELIQUIS	Tier-4	QL (60 EA per 30 days)

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
<i>enoxaparin</i>	Tier-2	
<i>fondaparinux</i>	Tier-2	
FRAGMIN SUBCUTANEOUS SOLUTION	Tier-3	
FRAGMIN SUBCUTANEOUS SYRINGE	Tier-3	
<i>jantoven</i>	Tier-1	
PRADAXA	Tier-4	
<i>warfarin</i>	Tier-1	
XARELTO ORAL TABLET 10 MG	Tier-4	QL (35 EA per 30 days)
XARELTO ORAL TABLET 15 MG, 20 MG	Tier-4	
BLOOD, MISCELLANEOUS		
<i>anagrelide</i>	Tier-2	
<i>cilostazol</i>	Tier-2	
<i>pentoxifylline</i>	Tier-2	
STIMATE	Tier-4	
<i>ticlopidine</i>	Tier-2	
<i>tranexamic acid</i>	Tier-2	
CANCER DRUGS		
INJECTABLE AGENTS		
ABRAXANE	Tier-3	
ALIMTA INTRAVENOUS RECON SOLN 500 MG	Tier-3	
ALKERAN INTRAVENOUS	Tier-3	
<i>amifostine crystalline</i>	Tier-2	
ARRANON	Tier-3	
ARZERRA INTRAVENOUS SOLUTION 100 MG/5 ML	Tier-3	
AVASTIN	Tier-3	
<i>azacitidine</i>	Tier-2	
BELEODAQ	Tier-3	PA
BICNU	Tier-3	
<i>bleomycin injection recon soln 30 unit</i>	Tier-2	
BUSULFEX	Tier-3	
CAMPATH	Tier-3	
<i>carboplatin intravenous solution</i>	Tier-2	
<i>cisplatin</i>	Tier-2	
<i>cladribine</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
CLOLAR	Tier-3	
COSMEGEN	Tier-3	
<i>cytarabine</i>	Tier-2	
<i>cytarabine (pf) injection solution 2 gram/20 ml (100 mg/ml)</i>	Tier-2	
CYTOVENE	Tier-3	
<i>dacarbazine intravenous recon soln 200 mg</i>	Tier-2	
DACOGEN	Tier-3	
<i>daunorubicin intravenous solution</i>	Tier-2	
<i>decitabine</i>	Tier-2	
<i>dexrazoxane hcl intravenous recon soln 250 mg</i>	Tier-2	
DOCEFREZ	Tier-3	
<i>docetaxel intravenous solution 80 mg/4 ml (20 mg/ml), 80 mg/8 ml (10 mg/ml)</i>	Tier-2	
<i>doxorubicin intravenous solution 50 mg/25 ml</i>	Tier-2	
ELITEK INTRAVENOUS RECON SOLN 1.5 MG	Tier-3	
ELLENCE INTRAVENOUS SOLUTION 200 MG/100 ML	Tier-3	
ELSPAR	Tier-3	
<i>epirubicin intravenous solution 50 mg/25 ml</i>	Tier-2	
ERBITUX INTRAVENOUS SOLUTION 100 MG/50 ML	Tier-3	
ERWINAZE	Tier-5	
ETOPOPHOS	Tier-3	
<i>etoposide intravenous</i>	Tier-2	
FASLODEX	Tier-3	
<i>fludarabine intravenous recon soln</i>	Tier-2	
<i>gemcitabine intravenous recon soln 1 gram</i>	Tier-2	
HALAVEN	Tier-3	
HERCEPTIN	Tier-3	
<i>idarubicin</i>	Tier-2	
IFEX INTRAVENOUS RECON SOLN 3 GRAM	Tier-3	
<i>ifosfamide intravenous recon soln 1 gram</i>	Tier-2	
<i>irinotecan intravenous solution 100 mg/5 ml</i>	Tier-2	
ISTODAX	Tier-3	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
IXEMPRA INTRAVENOUS RECON SOLN 45 MG	Tier-3	
JEVTANA	Tier-3	
KADCYLA INTRAVENOUS RECON SOLN 100 MG	Tier-3	PA
<i>leuprolide</i>	Tier-2	
<i>melphalan</i>	Tier-2	
<i>mitomycin intravenous recon soln 20 mg</i>	Tier-2	
<i>mitoxantrone</i>	Tier-2	
MUSTARGEN	Tier-3	
ONCASPAR	Tier-3	
<i>oxaliplatin intravenous solution 100 mg/20 ml</i>	Tier-2	
<i>paclitaxel</i>	Tier-2	
PERJETA	Tier-3	PA
PROLEUKIN	Tier-3	
RITUXAN	Tier-3	PA
SYLATRON	Tier-5	PA; QL (4 EA per 28 days)
SYNRIBO	Tier-3	
TAXOTERE INTRAVENOUS SOLUTION 80 MG/4 ML (20 MG/ML)	Tier-3	
<i>toposar</i>	Tier-2	
<i>topotecan intravenous recon soln</i>	Tier-2	
TORISEL	Tier-3	
TREANDA INTRAVENOUS RECON SOLN 100 MG	Tier-3	
TRISENOX	Tier-3	
UVADEX	Tier-3	
VECTIBIX INTRAVENOUS SOLUTION 100 MG/5 ML (20 MG/ML)	Tier-3	
VELCADE	Tier-3	
VIDAZA	Tier-3	
<i>vinblastine intravenous solution</i>	Tier-2	
<i>vincasar pfs intravenous solution 1 mg/ml</i>	Tier-2	
<i>vincristine intravenous solution 1 mg/ml</i>	Tier-2	
<i>vinorelbine intravenous solution 50 mg/5 ml</i>	Tier-2	
YERVOY INTRAVENOUS SOLUTION 50 MG/10 ML (5 MG/ML)	Tier-3	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
ZALTRAP INTRAVENOUS SOLUTION 100 MG/4 ML (25 MG/ML)	Tier-3	
ZANOSAR	Tier-3	
ORAL AGENTS		
8-MOP	Tier-3	
AFINITOR	Tier-5	PA; QL (30 EA per 30 days)
AFINITOR DISPERZ	Tier-5	PA; QL (60 EA per 30 Days)
ALKERAN ORAL	Tier-3	* Part B
<i>anastrozole</i>	Tier-2	
<i>bicalutamide</i>	Tier-2	
BOSULIF ORAL TABLET 100 MG	Tier-5	PA; QL (120 EA per 30 days)
BOSULIF ORAL TABLET 500 MG	Tier-5	PA; QL (30 EA per 30 days)
<i>capecitabine</i>	Tier-2	* Part B
CAPRELSA ORAL TABLET 100 MG	Tier-5	PA; QL (60 EA per 30 days)
CAPRELSA ORAL TABLET 300 MG	Tier-5	PA; QL (30 EA per 30 days)
CEENU ORAL CAPSULE 10 MG, 100 MG, 40 MG	Tier-3	
COMETRIQ	Tier-5	PA
CYCLOPHOSPHAMIDE ORAL CAPSULE	Tier-3	B/D
<i>cyclophosphamide oral tablet</i>	Tier-2	B/D
DROXIA	Tier-3	
EMCYT	Tier-3	
ERIVEDGE	Tier-5	PA
<i>exemestane</i>	Tier-2	
FARESTON	Tier-3	
<i>flutamide</i>	Tier-2	
GILOTRIF	Tier-5	PA
GLEEVEC	Tier-5	
HEXALEN	Tier-5	
<i>hydroxyurea</i>	Tier-2	
ICLUSIG	Tier-5	PA
IMBRUVICA	Tier-5	PA
INLYTA	Tier-5	PA
JAKAFI	Tier-5	PA
<i>letrozole</i>	Tier-2	
LEUKERAN	Tier-3	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
<i>lomustine</i>	Tier-2	
LYSODREN	Tier-3	
MATULANE	Tier-5	
<i>megestrol oral tablet</i>	Tier-1	
MEKINIST	Tier-5	PA
<i>mercaptopurine</i>	Tier-2	
MYLERAN	Tier-3	
NEXAVAR	Tier-5	PA; QL (220 EA per 30 days)
NILANDRON	Tier-3	
POMALYST	Tier-5	PA; QL (21 EA per 21 Days)
REVLIMID	Tier-5	PA; LA
SOLTAMOX	Tier-3	
SPRYCEL ORAL TABLET 100 MG, 140 MG	Tier-5	PA; QL (30 EA per 30 days)
SPRYCEL ORAL TABLET 20 MG, 50 MG, 70 MG, 80 MG	Tier-5	PA; QL (60 EA per 30 days)
STIVARGA	Tier-5	PA; QL (90 EA per 30 Days)
SUTENT	Tier-5	PA
TABLOID	Tier-3	
TAFINLAR	Tier-5	PA
<i>tamoxifen</i>	Tier-2	
TARCEVA ORAL TABLET 100 MG	Tier-5	QL (90 EA per 30 days)
TARCEVA ORAL TABLET 150 MG, 25 MG	Tier-5	QL (30 EA per 30 days)
TARGRETIN ORAL	Tier-5	
TASIGNA	Tier-5	PA
TEMODAR ORAL	Tier-3	* Part B
<i>temozolomide</i>	Tier-2	* Part B
THALOMID	Tier-5	
<i>tretinoin (chemotherapy)</i>	Tier-2	
TYKERB	Tier-5	PA; QL (180 EA per 30 days)
VOTRIENT	Tier-5	PA; QL (120 EA per 30 days)
XALKORI	Tier-5	PA
XELODA	Tier-3	* Part B
XTANDI	Tier-5	PA; QL (120 EA per 30 days)
ZELBORAF	Tier-5	PA
ZOLINZA	Tier-5	PA
ZYDELIG	Tier-4	PA; QL (60 EA per 30 days)

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
ZYKADIA	Tier-5	PA
ZYTIGA	Tier-5	PA; QL (120 EA per 30 days)
PROTECTIVE AGENTS		
FUSILEV	Tier-3	
<i>leucovorin calcium injection recon soln 100 mg, 350 mg</i>	Tier-2	
<i>leucovorin calcium oral</i>	Tier-2	
<i>mesna</i>	Tier-2	
MESNEX ORAL	Tier-4	
ZINECARD (AS HCL) INTRAVENOUS RECON SOLN 250 MG	Tier-3	
CARDIOVASCULAR AGENTS		
ACE INHIBITORS		
<i>benazepril</i>	Tier-1	
<i>captopril</i>	Tier-1	
<i>enalapril maleate</i>	Tier-1	
EPANED	Tier-4	
<i>fosinopril</i>	Tier-1	
<i>lisinopril</i>	Tier-1	
<i>moexipril</i>	Tier-1	
<i>perindopril erbumine</i>	Tier-1	
<i>quinapril</i>	Tier-1	
<i>ramipril</i>	Tier-1	
<i>trandolapril</i>	Tier-1	
ALPHA1 BLOCKERS		
CARDURA XL	Tier-4	
<i>doxazosin</i>	Tier-1	
<i>prazosin oral</i>	Tier-1	
<i>terazosin</i>	Tier-1	
ANGINA		
<i>isosorbide dinitrate oral</i>	Tier-1	
<i>isosorbide dinitrate sublingual tablet 2.5 mg</i>	Tier-1	
<i>isosorbide mononitrate</i>	Tier-2	
NITRO-BID	Tier-4	
<i>nitroglycerin intravenous</i>	Tier-2	
<i>nitroglycerin transdermal patch 24 hour</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
<i>nitroglycerin translingual spray, non-aerosol</i>	Tier-2	
NITROLINGUAL	Tier-4	
NITROMIST	Tier-4	
NITROSTAT	Tier-3	
RANEXA	Tier-3	
ANGIOTENSIN II RECEPTOR BLOCKERS		
BENICAR	Tier-3	
<i>candesartan</i>	Tier-1	
DIOVAN	Tier-3	
<i>eprosartan</i>	Tier-1	
<i>irbesartan</i>	Tier-1	
<i>losartan</i>	Tier-1	
<i>telmisartan</i>	Tier-1	
<i>valsartan</i>	Tier-1	
ANTI-ARRHYTHMICS AND CARDIAC GLYCOSIDES		
<i>amiodarone oral tablet 200 mg, 400 mg</i>	Tier-2	
<i>digoxin injection solution</i>	Tier-1	
<i>digoxin oral solution 50 mcg/ml</i>	Tier-1	
<i>digoxin oral tablet</i>	Tier-1	
<i>disopyramide phosphate oral capsule</i>	Tier-2	
<i>flecainide</i>	Tier-2	
LANOXIN ORAL	Tier-4	
LANOXIN PEDIATRIC	Tier-4	
<i>mexiletine</i>	Tier-2	
MULTAQ	Tier-4	
NORPACE CR	Tier-4	
PACERONE ORAL TABLET 100 MG, 200 MG, 400 MG	Tier-4	
<i>propafenone</i>	Tier-2	
<i>quinidine gluconate oral</i>	Tier-2	
<i>quinidine sulfate</i>	Tier-2	
<i>sorine</i>	Tier-2	
<i>sotalol oral tablet 160 mg, 240 mg, 80 mg</i>	Tier-1	
<i>sotalol af oral tablet 120 mg</i>	Tier-1	
TIKOSYN	Tier-3	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
ANTIHYPERTENSIVE FIXED-DOSE COMBINATION PRODUCTS		
<i>amlodipine-atorvastatin</i>	Tier-3	
<i>amlodipine-benazepril</i>	Tier-3	
AMTURNIDE	Tier-3	
<i>atenolol-chlorthalidone</i>	Tier-1	
AZOR	Tier-3	
<i>benazepril-hydrochlorothiazide</i>	Tier-1	
BENICAR HCT	Tier-3	
<i>bisoprolol-hydrochlorothiazide</i>	Tier-1	
<i>candesartan-hydrochlorothiazid</i>	Tier-1	
<i>captopril-hydrochlorothiazide</i>	Tier-1	
<i>clorpres</i>	Tier-2	
DUTOPROL	Tier-4	
<i>enalapril-hydrochlorothiazide</i>	Tier-1	
EXFORGE	Tier-4	
EXFORGE HCT	Tier-4	
<i>fosinopril-hydrochlorothiazide</i>	Tier-1	
<i>irbesartan-hydrochlorothiazide</i>	Tier-1	
<i>lisinopril-hydrochlorothiazide</i>	Tier-1	
<i>losartan-hydrochlorothiazide</i>	Tier-1	
<i>methyldopa-hydrochlorothiazide</i>	Tier-2	
<i>metoprolol ta-hydrochlorothiaz</i>	Tier-2	
<i>moexipril-hydrochlorothiazide</i>	Tier-1	
<i>nadolol-bendroflumethiazide</i>	Tier-2	
<i>propranolol-hydrochlorothiazid</i>	Tier-2	
<i>quinapril-hydrochlorothiazide</i>	Tier-1	
TARKA	Tier-4	
TEKAMLO	Tier-3	
TEKTURNA HCT	Tier-3	
<i>telmisartan-amlodipine</i>	Tier-1	
<i>telmisartan-hydrochlorothiazid</i>	Tier-1	
<i>triamterene-hydrochlorothiazid oral capsule 37.5-25 mg</i>	Tier-1	
<i>valsartan-hydrochlorothiazide</i>	Tier-1	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
BETA AND ALPHA BLOCKERS		
<i>carvedilol</i>	Tier-1	
COREG CR	Tier-4	
<i>labetalol intravenous solution</i>	Tier-2	
<i>labetalol oral</i>	Tier-2	
BETA BLOCKERS		
<i>acebutolol oral</i>	Tier-2	
<i>atenolol</i>	Tier-1	
<i>betaxolol oral</i>	Tier-2	
<i>bisoprolol fumarate</i>	Tier-2	
<i>metoprolol succinate</i>	Tier-2	
<i>metoprolol tartrate oral</i>	Tier-1	
<i>nadolol</i>	Tier-1	
<i>pindolol</i>	Tier-2	
<i>propranolol oral capsule, extended release 24 hr</i>	Tier-2	
<i>propranolol oral solution</i>	Tier-2	
<i>propranolol oral tablet</i>	Tier-1	
<i>timolol maleate oral</i>	Tier-2	
CALCIUM CHANNEL BLOCKERS		
<i>afeditab cr</i>	Tier-2	
<i>amlodipine</i>	Tier-2	
CARDENE IV IN SODIUM CHLORIDE	Tier-4	
<i>cartia xt</i>	Tier-2	
<i>dilt-cd oral capsule, extended release 24hr 300 mg</i>	Tier-2	
<i>dilt-xr</i>	Tier-2	
<i>diltiazem hcl oral capsule, extended release 180 mg, 360 mg, 420 mg</i>	Tier-2	
<i>diltiazem hcl oral capsule, extended release 12 hr</i>	Tier-2	
<i>diltiazem hcl oral capsule, extended release 24hr 120 mg, 240 mg, 300 mg</i>	Tier-2	
<i>diltiazem hcl oral tablet</i>	Tier-1	
<i>felodipine</i>	Tier-2	
<i>isradipine</i>	Tier-2	
<i>matzim la</i>	Tier-2	
<i>nicardipine oral</i>	Tier-2	
<i>nifedical xl</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
<i>nifedipine oral capsule</i>	Tier-2	
<i>nifedipine oral tablet extended release 24hr</i>	Tier-2	
<i>nimodipine</i>	Tier-2	
<i>nisoldipine</i>	Tier-2	
<i>taztia xt</i>	Tier-2	
<i>verapamil oral</i>	Tier-1	
CENTRALLY ACTING AGENTS		
<i>clonidine</i>	Tier-2	
<i>clonidine hcl oral tablet</i>	Tier-1	
<i>guanfacine</i>	Tier-1	
<i>methyldopa</i>	Tier-2	
<i>reserpine</i>	Tier-2	
DIRECT RENIN INHIBITORS		
TEKTURNA	Tier-3	
DIURETICS		
<i>amiloride oral</i>	Tier-2	
<i>amiloride-hydrochlorothiazide</i>	Tier-1	
<i>bumetanide oral</i>	Tier-1	
<i>chlorothiazide</i>	Tier-2	
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	Tier-1	
<i>furosemide injection</i>	Tier-2	
<i>furosemide oral solution 10 mg/ml, 40 mg/5 ml</i>	Tier-2	
<i>furosemide oral tablet</i>	Tier-1	
<i>hydrochlorothiazide</i>	Tier-1	
<i>indapamide</i>	Tier-1	
<i>methyclothiazide</i>	Tier-2	
<i>metolazone</i>	Tier-2	
<i>spironolacton-hydrochlorothiaz</i>	Tier-2	
<i>spironolactone oral tablet 100 mg, 25 mg</i>	Tier-1	
<i>toremide intravenous solution 20 mg/2 ml (10 mg/ml)</i>	Tier-2	
<i>toremide oral</i>	Tier-2	
<i>triamterene-hydrochlorothiazid oral capsule 50-25 mg</i>	Tier-1	
<i>triamterene-hydrochlorothiazid oral tablet</i>	Tier-1	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
LIPID LOWERING AGENTS		
<i>atorvastatin</i>	Tier-2	
<i>cholestyramine light oral powder in packet</i>	Tier-2	
<i>colestipol oral granules</i>	Tier-2	
<i>colestipol oral tablet</i>	Tier-2	
<i>fenofibrate</i>	Tier-2	
<i>fenofibrate micronized</i>	Tier-2	
<i>fenofibrate nanocrystallized</i>	Tier-2	
<i>fenofibric acid (choline)</i>	Tier-2	
<i>fluvastatin</i>	Tier-1	
<i>gemfibrozil oral</i>	Tier-2	
JUXTAPID	Tier-5	PA
KYNAMRO	Tier-5	PA
<i>lovastatin</i>	Tier-1	
LOVAZA	Tier-3	
<i>niacin oral tablet extended release 24 hr</i>	Tier-3	
<i>niacor</i>	Tier-2	
<i>omega-3 acid ethyl esters</i>	Tier-3	
<i>pravastatin</i>	Tier-1	
PREVALITE ORAL POWDER	Tier-4	
SIMCOR	Tier-3	
<i>simvastatin</i>	Tier-1	
VYTORIN 10-10	Tier-4	
VYTORIN 10-20	Tier-4	
VYTORIN 10-40	Tier-4	
VYTORIN 10-80	Tier-4	
WELCHOL	Tier-4	
ZETIA	Tier-3	
POTASSIUM REPLACEMENT		
K-TAB ORAL TABLET EXTENDED RELEASE 10 MEQ	Tier-4	
<i>klor-con 8</i>	Tier-2	
<i>klor-con m10</i>	Tier-2	
KLOR-CON M15	Tier-4	
<i>klor-con m20</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
<i>potassium chloride oral capsule, extended release 10 meq</i>	Tier-1	
<i>potassium chloride oral capsule, extended release 8 meq</i>	Tier-2	
<i>potassium chloride oral tablet,er particles/crystals</i>	Tier-2	
SELECTIVE ALDOSTERONE BLOCKER		
<i>eplerenone</i>	Tier-2	STPA
<i>spironolactone oral tablet 50 mg</i>	Tier-1	
VASODILATORS		
BIDIL	Tier-3	
<i>hydralazine</i>	Tier-1	
<i>minoxidil oral</i>	Tier-2	
DIABETES MELLITUS		
DIABETIC SUPPLIES		
ACCU-CHEK ACTIVE TEST	Tier-3	* Part B
ACCU-CHEK AVIVA	Tier-3	* Part B
ACCU-CHEK AVIVA PLUS TEST STRP	Tier-3	* Part B
ACCU-CHEK COMFORT CURVE TEST	Tier-3	* Part B
ACCU-CHEK COMPACT TEST	Tier-3	* Part B
ACCU-CHEK SMARTVIEW TEST STRIP	Tier-3	* Part B
<i>alcohol swabs</i>	Tier-2	
<i>gauze bandage topical bandage 2 x 2.5 "-yard</i>	Tier-2	
<i>huber safety needles (disp.)</i>	Tier-2	
INSULIN PEN NEEDLE NEEDLE 31	Tier-3	
INSULIN SYRINGE SYRINGE 0.3 ML 29 X 1"	Tier-3	
INSULIN SYRINGE NEEDLELESS	Tier-3	
<i>insulin syringe-needle u-100 syringe 0.3 ml 30 x 1/2"</i>	Tier-2	
ONE TOUCH TEST	Tier-3	* Part B
ONE TOUCH ULTRA TEST	Tier-3	* Part B
ONE TOUCH VERIO	Tier-3	* Part B
GLUCOSE ELEVATING		
GLUCAGEN HYPOKIT	Tier-3	
GLUCAGON EMERGENCY KIT (HUMAN)	Tier-3	
PROGLYCEM	Tier-4	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
INSULINS		
HUMALOG SUBCUTANEOUS SOLUTION	Tier-3	
HUMALOG KWIKPEN	Tier-3	
HUMALOG MIX 50-50	Tier-3	
HUMALOG MIX 50-50 KWIKPEN	Tier-3	
HUMALOG MIX 75-25	Tier-3	
HUMALOG MIX 75-25 KWIKPEN	Tier-3	
HUMULIN 70/30	Tier-3	
HUMULIN 70/30 PEN	Tier-3	
HUMULIN N	Tier-3	
HUMULIN N PEN	Tier-3	
HUMULIN R	Tier-3	
HUMULIN R U-500 "CONCENTRATED"	Tier-3	
LANTUS	Tier-3	
LANTUS SOLOSTAR	Tier-3	
LEVEMIR	Tier-3	
LEVEMIR FLEXPEN	Tier-3	
NOVOLIN 70/30	Tier-3	
NOVOLIN N	Tier-3	
NOVOLIN R	Tier-3	
NOVOLOG	Tier-3	
NOVOLOG FLEXPEN	Tier-3	
NOVOLOG MIX 70-30	Tier-3	
NOVOLOG MIX 70-30 FLEXPEN	Tier-3	
NON-INSULIN INJECTABLES		
BYDUREON SUBCUTANEOUS SUSPENSION,EXTENDED REL RECON	Tier-3	
BYETTA	Tier-3	
SYMLINPEN 120	Tier-3	
SYMLINPEN 60	Tier-3	
VICTOZA 3-PAK	Tier-3	
ORAL AGENTS		
<i>acarbose</i>	Tier-1	
ACTOPLUS MET XR	Tier-4	
<i>chlorpropamide</i>	Tier-1	
FARXIGA	Tier-4	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
<i>glimepiride</i>	Tier-1	
<i>glipizide</i>	Tier-1	
<i>glipizide-metformin</i>	Tier-1	
<i>glyburide</i>	Tier-1	
<i>glyburide micronized</i>	Tier-1	
<i>glyburide-metformin</i>	Tier-1	
INVOKANA	Tier-4	
JANUMET	Tier-3	
JANUMET XR	Tier-3	
JANUVIA	Tier-3	
JENTADUETO	Tier-3	
<i>metformin oral tablet</i>	Tier-1	
<i>metformin oral tablet extended release 24 hr</i>	Tier-1	
<i>metformin oral tablet extended release 24hr 1,000 mg</i>	Tier-1	
<i>nateglinide</i>	Tier-1	
<i>pioglitazone</i>	Tier-3	
<i>pioglitazone-glimepiride</i>	Tier-2	
<i>pioglitazone-metformin</i>	Tier-3	
PRANDIMET	Tier-4	
PRANDIN	Tier-3	
<i>repaglinide</i>	Tier-1	
RIOMET	Tier-3	
<i>tolazamide</i>	Tier-1	
<i>tolbutamide</i>	Tier-1	
TRADJENTA	Tier-3	
EAR, NOSE AND THROAT		
EAR		
<i>acetazol hc</i>	Tier-2	
<i>acetic acid otic</i>	Tier-2	
CIPRO HC	Tier-3	
CIPRODEX	Tier-3	
COLY-MYCIN S	Tier-4	
CORTISPORIN-TC	Tier-4	
<i>fluocinolone acetonide oil</i>	Tier-2	
<i>hydrocortisone-acetic acid</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
<i>ofloxacin otic</i>	Tier-2	
VOSOL-HC	Tier-4	
MOUTH AND THROAT		
<i>cevimeline</i>	Tier-2	
<i>chlorhexidine gluconate mucous membrane</i>	Tier-1	
<i>doxycycline hyclate oral tablet 20 mg</i>	Tier-1	
<i>periogard</i>	Tier-1	
<i>pilocarpine hcl oral</i>	Tier-2	
<i>sodium fluoride oral tablet</i>	Tier-2	
<i>triamcinolone acetonide dental</i>	Tier-2	
NOSE		
ASTEPRO NASAL SPRAY, NON-AEROSOL	Tier-3	QL (120 ML per 90 days)
<i>azelastine nasal</i>	Tier-2	QL (120 ML per 90 days)
BACTROBAN NASAL	Tier-4	
<i>budesonide nasal</i>	Tier-2	QL (68.8 GM per 90 days)
<i>cyproheptadine</i>	Tier-2	
<i>desloratadine</i>	Tier-2	
<i>flunisolide nasal spray, non-aerosol 25 mcg (0.025 %)</i>	Tier-2	QL (150 ML per 90 Days)
<i>fluticasone nasal</i>	Tier-2	QL (48 GM per 90 days)
<i>hydroxyzine hcl intramuscular</i>	Tier-2	
<i>hydroxyzine hcl oral syrup 10 mg/5 ml</i>	Tier-2	
<i>hydroxyzine hcl oral tablet</i>	Tier-2	
<i>hydroxyzine pamoate</i>	Tier-2	
<i>ipratropium bromide nasal spray, non-aerosol 0.03 %</i>	Tier-2	QL (180 ML per 90 days)
<i>ipratropium bromide nasal spray, non-aerosol 0.06 %</i>	Tier-2	QL (90 ML per 90 days)
<i>levocetirizine</i>	Tier-2	
NASONEX	Tier-3	QL (102 GM per 90 days)
<i>triamcinolone acetonide nasal</i>	Tier-3	QL (49.5 GM per 90 days)
TYZINE NASAL DROPS	Tier-4	
EYE		
ALLERGY		
ALOCRIAL	Tier-4	
ALOMIDE	Tier-4	
<i>azelastine ophthalmic</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
<i>cromolyn ophthalmic</i>	Tier-2	
EMADINE	Tier-4	
<i>epinastine</i>	Tier-2	
LASTACAFT	Tier-4	
<i>naphazoline</i>	Tier-2	
ANTI-INFECTIVES		
AZASITE	Tier-4	
<i>bacitracin ophthalmic</i>	Tier-2	
<i>bacitracin-polymyxin b ophthalmic</i>	Tier-2	
BESIVANCE	Tier-4	
BLEPHAMIDE	Tier-4	
BLEPHAMIDE S.O.P.	Tier-4	
<i>ciprofloxacin ophthalmic</i>	Tier-2	
<i>erythromycin ophthalmic</i>	Tier-2	
GARAMYCIN OPHTHALMIC DROPS	Tier-4	
<i>gatifloxacin</i>	Tier-2	
<i>gentak ophthalmic ointment</i>	Tier-1	
<i>gentamicin ophthalmic</i>	Tier-1	
<i>levofloxacin ophthalmic</i>	Tier-2	
MOXEZA	Tier-4	
<i>neomycin-bacitracin-poly-hc</i>	Tier-2	
<i>neomycin-bacitracin-polymyxin</i>	Tier-2	
<i>neomycin-polymyxin-hc otic drops,suspension</i>	Tier-2	
<i>ofloxacin ophthalmic</i>	Tier-2	
<i>polymyxin b sulf-trimethoprim</i>	Tier-1	
<i>sulfacetamide sodium ophthalmic</i>	Tier-2	
<i>sulfacetamide-prednisolone</i>	Tier-2	
TOBRADEX	Tier-4	
TOBRADEX ST	Tier-4	
<i>tobramycin</i>	Tier-2	
<i>tobramycin-dexamethasone</i>	Tier-2	
VIGAMOX	Tier-4	
ZYMAXID	Tier-4	
ANTI-INFLAMMATORIES		
ALREX	Tier-4	
<i>bromfenac</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
<i>dexamethasone sodium phosphate ophthalmic</i>	Tier-2	
<i>diclofenac sodium ophthalmic</i>	Tier-2	
FLAREX	Tier-4	
<i>fluorometholone</i>	Tier-2	
<i>flurbiprofen sodium</i>	Tier-2	
FML FORTE	Tier-4	
FML S.O.P.	Tier-3	
<i>ketorolac ophthalmic</i>	Tier-2	
LOTEMAX OPHTHALMIC DROPS,SUSPENSION	Tier-4	
MAXIDEX	Tier-4	
<i>neomycin-polymyxin b-dexameth</i>	Tier-2	
<i>neomycin-polymyxin-gramicidin</i>	Tier-2	
<i>neomycin-polymyxin-hc ophthalmic</i>	Tier-2	
<i>neomycin-polymyxin-hc otic solution</i>	Tier-2	
NEVANAC	Tier-4	
PRED MILD	Tier-3	
PRED-G	Tier-3	
PRED-G S.O.P.	Tier-3	
<i>prednisolone acetate</i>	Tier-2	
PROLENSA	Tier-4	
VEXOL	Tier-3	
ZYLET	Tier-4	
ANTIVIRALS		
<i>trifluridine</i>	Tier-2	
ZIRGAN	Tier-4	
GLAUCOMA		
<i>acetazolamide oral</i>	Tier-2	
ALPHAGAN P OPHTHALMIC DROPS 0.1 %	Tier-4	
<i>apraclonidine</i>	Tier-2	
AZOPT	Tier-3	
<i>betaxolol ophthalmic</i>	Tier-2	
BETIMOL	Tier-3	
BETOPTIC S	Tier-4	
<i>brimonidine</i>	Tier-2	
<i>carteolol</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
COMBIGAN	Tier-4	QL (10 ML per 30 days)
COSOPT	Tier-4	
<i>dorzolamide</i>	Tier-2	
<i>dorzolamide-timolol</i>	Tier-2	
IOPIDINE	Tier-4	
<i>latanoprost</i>	Tier-2	
<i>levobunolol ophthalmic drops 0.5 %</i>	Tier-1	
LUMIGAN OPHTHALMIC DROPS 0.01 %	Tier-4	STPA
<i>methazolamide oral</i>	Tier-2	
<i>metipranolol</i>	Tier-2	
<i>pilocarpine hcl ophthalmic drops 1 %, 2 %, 4 %</i>	Tier-2	
SIMBRINZA	Tier-4	
<i>timolol maleate ophthalmic drops</i>	Tier-1	
<i>timolol maleate ophthalmic gel forming solution</i>	Tier-2	
TRAVATAN Z	Tier-4	STPA
<i>travoprost (benzalkonium)</i>	Tier-2	
ZIOPTAN (PF)	Tier-4	STPA; QL (90 EA per 90 days)
OPHTHALMIC DRUGS, MISCELLANEOUS		
ALCAINE	Tier-4	
NATACYN	Tier-4	
RESTASIS	Tier-3	PA
GASTROINTESTINAL DRUGS		
EMESIS		
ALOXI	Tier-3	B/D; QL (5 ML per 7 days)
ANZEMET ORAL TABLET 100 MG	Tier-3	B/D; QL (5 EA per 7 days)
ANZEMET ORAL TABLET 50 MG	Tier-3	B/D; QL (3 EA per 7 days)
CESAMET	Tier-3	B/D; QL (30 EA per 7 days)
<i>compro</i>	Tier-2	
<i>dronabinol</i>	Tier-2	B/D; QL (21 EA per 7 Days)
EMEND ORAL CAPSULE 125 MG	Tier-3	B/D; QL (1 EA per 7 days)
EMEND ORAL CAPSULE 40 MG, 80 MG	Tier-3	B/D; QL (2 EA per 7 days)
EMEND ORAL CAPSULE,DOSE PACK	Tier-3	B/D; QL (3 EA per 7 days)
<i>granisetron hcl oral</i>	Tier-2	B/D; QL (10 EA per 7 days)
<i>meclizine oral tablet 12.5 mg, 25 mg</i>	Tier-2	
<i>metoclopramide hcl injection solution</i>	Tier-2	
<i>metoclopramide hcl oral</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
<i>ondansetron</i>	Tier-2	B/D; QL (12 EA per 7 days)
<i>ondansetron hcl oral solution</i>	Tier-2	B/D; QL (150 ML per 7 days)
<i>ondansetron hcl oral tablet 24 mg</i>	Tier-2	B/D; QL (4 EA per 7 days)
<i>ondansetron hcl oral tablet 4 mg, 8 mg</i>	Tier-2	B/D; QL (12 EA per 7 days)
<i>prochlorperazine</i>	Tier-2	
<i>prochlorperazine edisylate injection solution 10 mg/2 ml (5 mg/ml)</i>	Tier-2	
<i>prochlorperazine maleate oral</i>	Tier-2	
SANCUSO	Tier-4	B/D; QL (1 EA per 7 days)
TRANSDERM-SCOP	Tier-4	
ENZYMES		
BUPHENYL	Tier-5	
CARBAGLU	Tier-3	PA
CREON	Tier-3	
CYSTAGON	Tier-4	
PANCREAZE	Tier-4	
PERTZYE	Tier-4	
ULTRESA	Tier-4	
VIOKACE	Tier-4	
ZENPEP	Tier-4	
GASTROINTESTINAL DRUGS, MISCELLANEOUS		
CANTIL	Tier-4	
<i>constulose</i>	Tier-2	
<i>cromolyn oral</i>	Tier-2	
<i>dicyclomine oral capsule</i>	Tier-1	
<i>dicyclomine oral solution</i>	Tier-1	
<i>dicyclomine oral tablet</i>	Tier-1	
<i>enulose</i>	Tier-2	
FULYZAQ	Tier-3	PA
GATTEX ONE-VIAL	Tier-5	PA
<i>generlac</i>	Tier-2	
<i>glycopyrrolate oral</i>	Tier-2	
HALFLYTELY-BISACODYL W-FLAV PK	Tier-3	
KRISTALOSE	Tier-3	
<i>lactulose oral solution 10 gram/15 ml</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
<i>levocarnitine oral tablet</i>	Tier-2	
<i>levocarnitine (with sugar)</i>	Tier-2	
<i>loperamide oral capsule</i>	Tier-2	
LOTRONEX	Tier-3	
<i>megestrol oral suspension 400 mg/10 ml (40 mg/ml)</i>	Tier-2	
MOVIPREP	Tier-4	
MYALEPT	Tier-5	PA; QL (30 EA per 30 days)
OSMOPREP	Tier-4	
<i>polyethylene glycol 3350 oral powder</i>	Tier-2	
<i>propantheline</i>	Tier-2	
SUCLEAR	Tier-4	
SUPREP	Tier-4	
<i>trilyte with flavor packets</i>	Tier-2	
<i>ursodiol</i>	Tier-2	
GASTROINTESTINAL DRUGS, PEPTIC ULCER TREATMENT, REFLUX (GERD)		
<i>amoxicil-clarithromy-lansopraz</i>	Tier-2	
<i>cimetidine</i>	Tier-1	
<i>cimetidine hcl oral</i>	Tier-2	
<i>famotidine oral suspension</i>	Tier-2	
<i>famotidine oral tablet 20 mg, 40 mg</i>	Tier-1	
<i>lansoprazole oral capsule, delayed release(dr/ec)</i>	Tier-3	
<i>methscopolamine oral</i>	Tier-2	
<i>misoprostol</i>	Tier-2	
<i>nizatidine</i>	Tier-2	
<i>omeprazole oral capsule, delayed release(dr/ec)</i>	Tier-2	
<i>omeprazole-sodium bicarbonate</i>	Tier-2	
<i>pantoprazole oral</i>	Tier-2	
PREVPAC	Tier-4	
PYLERA	Tier-3	
<i>rabeprazole</i>	Tier-3	
<i>ranitidine hcl oral capsule</i>	Tier-1	
<i>ranitidine hcl oral syrup</i>	Tier-2	
<i>ranitidine hcl oral tablet 150 mg, 300 mg</i>	Tier-1	
RELISTOR SUBCUTANEOUS KIT	Tier-3	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
<i>sucralfate oral tablet</i>	Tier-2	
INFLAMMATORY BOWEL DISEASE		
AMITIZA	Tier-3	
APRISO	Tier-3	
ASACOL HD	Tier-3	
<i>balsalazide</i>	Tier-2	
<i>budesonide oral</i>	Tier-2	
CANASA	Tier-3	
<i>colocort</i>	Tier-2	
DELZICOL	Tier-3	
DIPENTUM	Tier-3	
ENTOCORT EC	Tier-4	
<i>hydrocortisone rectal enema</i>	Tier-2	
LINZESS	Tier-3	QL (30 EA per 30 days)
PENTASA	Tier-3	
SFROWASA	Tier-4	
<i>sulfasalazine oral tablet</i>	Tier-2	
<i>sulfazine ec</i>	Tier-2	
UCERIS ORAL	Tier-4	
HOME INFUSION THERAPY		
ACUTE CARE DRUGS		
ABELCET	Tier-3	HI
<i>acetazolamide sodium</i>	Tier-2	HI
<i>acyclovir sodium intravenous solution</i>	Tier-2	HI
AMBISOME	Tier-3	HI
<i>amikacin injection solution 500 mg/2 ml</i>	Tier-2	HI; Part B
<i>amphotericin b</i>	Tier-2	HI
<i>ampicillin sodium injection recon soln 1 gram, 10 gram, 125 mg</i>	Tier-2	HI; Part B
<i>ampicillin-sulbactam injection recon soln 15 gram, 3 gram</i>	Tier-2	HI; Part B
ANZEMET INTRAVENOUS SOLUTION 100 MG/5 ML	Tier-3	HI; QL (10 ML per 7 days)
ARGATROBAN	Tier-4	HI
ARGATROBAN IN 0.9 % SOD CHLOR	Tier-4	HI
ATGAM	Tier-3	HI; Part B
<i>atropine injection syringe 0.05 mg/ml</i>	Tier-2	HI

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
<i>atropine injection syringe 0.1 mg/ml</i>	Tier-2	
AVELOX IN NAACL (ISO-OSMOTIC)	Tier-3	HI; Part B
AZACTAM INJECTION RECON SOLN 2 GRAM	Tier-3	HI; Part B
AZACTAM IN DEXTROSE (ISO-OSM)	Tier-3	HI; Part B
<i>azithromycin intravenous</i>	Tier-2	HI; Part B
<i>aztreonam injection recon soln 1 gram</i>	Tier-2	HI; Part B
<i>benztropine injection</i>	Tier-2	HI
BONIVA INTRAVENOUS	Tier-3	PA; HI
<i>bumetanide injection</i>	Tier-2	HI
<i>buprenorphine hcl injection syringe</i>	Tier-2	HI
<i>butorphanol tartrate injection</i>	Tier-2	HI
<i>calcitriol intravenous solution 1 mcg/ml</i>	Tier-2	HI
CANCIDAS	Tier-3	HI
CAPASTAT	Tier-3	HI
<i>cefazolin injection recon soln 1 gram, 10 gram, 500 mg</i>	Tier-2	HI; Part B
<i>cefazolin in dextrose (iso-os) intravenous piggyback 1 gram/50 ml</i>	Tier-2	HI; Part B
<i>cefepime</i>	Tier-2	HI; Part B
<i>cefotaxime injection recon soln 1 gram, 2 gram, 500 mg</i>	Tier-2	HI
<i>cefotaxime injection recon soln 10 gram</i>	Tier-2	HI; Part B
<i>cefotetan</i>	Tier-2	HI; Part B
<i>cefoxitin</i>	Tier-2	HI; Part B
<i>cefoxitin in dextrose, iso-osm</i>	Tier-2	HI; Part B
<i>ceftazidime injection recon soln 1 gram, 2 gram, 6 gram</i>	Tier-2	HI; Part B
<i>ceftazidime in d5w</i>	Tier-2	HI; Part B
<i>ceftriaxone injection recon soln 10 gram, 250 mg, 500 mg</i>	Tier-2	HI; Part B
<i>ceftriaxone intravenous recon soln</i>	Tier-2	HI; Part B
<i>cefuroxime sodium injection recon soln 1.5 gram, 750 mg</i>	Tier-2	HI; Part B
<i>cefuroxime sodium intravenous</i>	Tier-2	HI; Part B
<i>chloramphenicol sod succinate</i>	Tier-2	HI; Part B
<i>cidofovir</i>	Tier-2	HI
<i>cimetidine hcl injection</i>	Tier-2	HI

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
<i>ciprofloxacin intravenous solution 400 mg/40 ml</i>	Tier-2	HI; Part B
<i>ciprofloxacin in 5 % dextrose intravenous piggyback 200 mg/100 ml</i>	Tier-2	HI; Part B
CLEOCIN INJECTION	Tier-3	HI; Part B
CLEOCIN IN 5 % DEXTROSE	Tier-3	HI; Part B
<i>clindamycin phosphate intravenous solution 600 mg/4 ml</i>	Tier-2	HI; Part B
<i>colistin (colistimethate na)</i>	Tier-2	HI; Part B
CUBICIN	Tier-3	HI; Part B
<i>cyclosporine intravenous</i>	Tier-2	B/D; HI
CYKLOKAPRON	Tier-3	HI
<i>dexamethasone sodium phosphate injection solution 4 mg/ml</i>	Tier-2	HI
<i>diltiazem hcl intravenous</i>	Tier-2	HI
DORIBAX INTRAVENOUS RECON SOLN 500 MG	Tier-3	HI; Part B
<i>duramorph (pf)</i>	Tier-2	HI
ERAXIS(WATER DILUENT) INTRAVENOUS RECON SOLN 100 MG	Tier-3	HI
ERYTHROCIN INTRAVENOUS RECON SOLN 500 MG	Tier-3	HI; Part B
<i>esomeprazole sodium</i>	Tier-2	
<i>fluconazole in dextrose(iso-o) intravenous piggyback 400 mg/200 ml</i>	Tier-2	HI; Part B
FORTAZ INJECTION RECON SOLN 2 GRAM, 6 GRAM	Tier-3	HI; Part B
FORTAZ IN DEXTROSE 5 %	Tier-3	HI; Part B
<i>foscarnet</i>	Tier-2	HI
<i>gentamicin injection solution 40 mg/ml</i>	Tier-2	HI; Part B
<i>gentamicin in nacl (iso-osm) intravenous piggyback 100 mg/100 ml, 60 mg/50 ml, 70 mg/50 ml, 80 mg/100 ml, 80 mg/50 ml, 90 mg/100 ml</i>	Tier-2	HI; Part B
<i>gentamicin sulfate (pf) intravenous solution 80 mg/8 ml</i>	Tier-2	HI; Part B
<i>granisetron (pf) intravenous solution 100 mcg/ml</i>	Tier-2	B/D; HI; QL (40 ML per 7 days)
<i>granisetron hcl intravenous solution 1 mg/ml (1 ml)</i>	Tier-2	B/D; HI; QL (40 ML per 7 days)
HECTOROL INTRAVENOUS SOLUTION 4 MCG/2 ML	Tier-3	HI

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
<i>heparin (porcine) injection solution</i>	Tier-2	HI
<i>heparin (porcine) in 5 % dex intravenous parenteral solution 20,000 unit/500 ml (40 unit/ml)</i>	Tier-2	HI
<i>heparin (porcine) in nacl (pf) intravenous parenteral solution 2,000 unit/1,000 ml</i>	Tier-2	HI
<i>heparin(porcine) in 0.45% nacl intravenous parenteral solution 25,000 unit/250 ml, 25,000 unit/500 ml</i>	Tier-2	HI
<i>hydromorphone (pf) injection solution 10 mg/ml</i>	Tier-2	HI
<i>imipenem-cilastatin</i>	Tier-2	HI; Part B
INVANZ INJECTION	Tier-3	HI; Part B
<i>isoniazid injection</i>	Tier-2	HI
<i>kanamycin</i>	Tier-2	HI; Part B
<i>lactated ringers intravenous</i>	Tier-2	HI
<i>levocarnitine intravenous</i>	Tier-2	HI
<i>levofloxacin intravenous</i>	Tier-2	HI; Part B
<i>levofloxacin in d5w intravenous piggyback 500 mg/100 ml</i>	Tier-2	HI; Part B
<i>lidocaine (pf) injection solution 10 mg/ml (1 %), 5 mg/ml (0.5 %)</i>	Tier-2	HI
LINCOCIN	Tier-3	HI; Part B
<i>meropenem intravenous recon soln 500 mg</i>	Tier-2	HI; Part B
MERREM INTRAVENOUS RECON SOLN 500 MG	Tier-3	HI; Part B
<i>methadone injection</i>	Tier-2	HI
<i>methotrexate sodium (pf)</i>	Tier-2	HI
<i>metoprolol tartrate intravenous solution</i>	Tier-2	HI
<i>metronidazole in nacl (iso-os)</i>	Tier-2	HI; Part B
MYCAMINE	Tier-3	HI
<i>nafcillin injection recon soln 1 gram, 10 gram</i>	Tier-2	HI; Part B
<i>nafcillin in dextrose iso-osm intravenous piggyback 1 gram/50 ml</i>	Tier-2	HI; Part B
<i>ondansetron hcl (pf) injection solution</i>	Tier-2	B/D; HI
<i>oxacillin injection recon soln 1 gram, 10 gram</i>	Tier-2	HI; Part B
<i>oxacillin in dextrose(iso-osm)</i>	Tier-2	HI; Part B
<i>pamidronate intravenous solution</i>	Tier-2	HI
<i>pantoprazole intravenous</i>	Tier-2	HI

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
<i>penicillin g pot in dextrose intravenous piggyback 2 million unit/50 ml, 3 million unit/50 ml</i>	Tier-2	HI; Part B
<i>penicillin g potassium injection recon soln 5 million unit</i>	Tier-2	HI; Part B
<i>penicillin g sodium</i>	Tier-2	HI; Part B
PFIZERPEN-G INJECTION RECON SOLN 20 MILLION UNIT	Tier-3	HI; Part B
<i>piperacillin-tazobactam intravenous recon soln 3.375 gram, 4.5 gram</i>	Tier-2	HI; Part B
<i>polymyxin b sulfate</i>	Tier-2	HI; Part B
<i>potassium chloride intravenous piggyback 20 meq/100 ml, 30 meq/100 ml</i>	Tier-2	HI
PRIMAXIN IV	Tier-3	HI; Part B
PROGRAF INTRAVENOUS	Tier-3	B/D; HI
PROTONIX INTRAVENOUS	Tier-3	HI
RETROVIR INTRAVENOUS	Tier-3	HI
<i>streptomycin intramuscular</i>	Tier-2	
<i>sulfamethoxazole-trimethoprim intravenous</i>	Tier-2	HI
SYNERCID	Tier-3	HI; Part B
TEFLARO	Tier-3	HI; Part B
TIMENTIN INTRAVENOUS RECON SOLN 3.1 GRAM	Tier-3	HI; Part B
<i>tobramycin in 0.9 % nacl</i>	Tier-2	HI; Part B
<i>tobramycin sulfate injection solution</i>	Tier-2	HI; Part B
TYGACIL	Tier-3	HI; Part B
<i>valproate sodium</i>	Tier-2	HI
<i>vancomycin intravenous recon soln 1,000 mg, 10 gram, 500 mg</i>	Tier-2	HI; Part B
VFEND IV	Tier-3	HI
VIBATIV INTRAVENOUS RECON SOLN 250 MG	Tier-3	
VISTIDE	Tier-3	HI
<i>voriconazole intravenous</i>	Tier-2	HI
ZEMPLAR INTRAVENOUS	Tier-3	HI
ZINACEF IN DEXTROSE (ISO-OSM)	Tier-3	HI; Part B
ZINACEF IN STERILE WATER	Tier-3	HI; Part B
ZOSYN INTRAVENOUS RECON SOLN 3.375 GRAM	Tier-3	HI; Part B

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
ZOSYN IN DEXTROSE (ISO-OSM) INTRAVENOUS PIGGYBACK 2.25 GRAM/50 ML, 3.375 GRAM/50 ML	Tier-3	HI; Part B
ZYVOX INTRAVENOUS PARENTERAL SOLUTION 600 MG/300 ML	Tier-3	HI; Part B
ELECTROLYTES		
<i>ammonium chloride</i>	Tier-2	HI
<i>d10 % & 0.45 % sodium chloride</i>	Tier-2	HI
<i>d2.5 %-0.45 % sodium chloride</i>	Tier-2	HI
<i>d5 % and 0.9 % sodium chloride</i>	Tier-2	HI
<i>d5 %-0.45 % sodium chloride</i>	Tier-2	HI
<i>dextrose 10 % and 0.2 % nacl</i>	Tier-2	HI
<i>dextrose 10 % in water (d10w) intravenous parenteral solution</i>	Tier-2	HI
<i>dextrose 5 % in water (d5w) intravenous parenteral solution</i>	Tier-2	HI
<i>dextrose 5 %-lactated ringers</i>	Tier-2	HI
<i>dextrose 5%-0.2 % sod chloride</i>	Tier-2	HI
<i>dextrose 5%-0.3 % sod.chloride</i>	Tier-2	HI
IONOSOL-B IN D5W	Tier-3	HI
IONOSOL-MB IN D5W	Tier-3	HI
ISOLYTE S IN 5 % DEXTROSE	Tier-3	HI
ISOLYTE-H IN 5 % DEXTROSE	Tier-3	HI
ISOLYTE-P IN 5 % DEXTROSE	Tier-3	HI
ISOLYTE-S	Tier-3	HI
<i>magnesium sulfate injection</i>	Tier-2	
NORMOSOL-M IN 5 % DEXTROSE	Tier-3	HI
NORMOSOL-R IN 5 % DEXTROSE	Tier-3	HI
NORMOSOL-R PH 7.4	Tier-3	HI
PLASMA-LYTE 148	Tier-3	HI
PLASMA-LYTE A	Tier-3	HI
PLASMA-LYTE-56 IN 5 % DEXTROSE	Tier-3	HI
<i>potassium chlorid-d5-0.45%nacl</i>	Tier-2	HI
<i>potassium chloride intravenous parenteral solution</i>	Tier-2	HI
<i>potassium chloride intravenous piggyback 10 meq/100 ml, 40 meq/100 ml</i>	Tier-2	HI

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
<i>potassium chloride in 0.9%nacl intravenous parenteral solution 20 meq/l, 40 meq/l</i>	Tier-2	HI
<i>potassium chloride in 5 % dex intravenous parenteral solution 20 meq/l, 30 meq/l, 40 meq/l</i>	Tier-2	HI
<i>potassium chloride in lr-d5 intravenous parenteral solution 20 meq/l</i>	Tier-2	HI
<i>potassium chloride-0.45 % nacl</i>	Tier-2	HI
<i>potassium chloride-d5-0.2%nacl intravenous parenteral solution 20 meq/l</i>	Tier-2	HI
<i>potassium chloride-d5-0.3%nacl intravenous parenteral solution 20 meq/l</i>	Tier-2	HI
<i>potassium chloride-d5-0.9%nacl</i>	Tier-2	HI
<i>ringers intravenous</i>	Tier-2	HI
<i>sodium chloride intravenous parenteral solution 2.5 meq/ml</i>	Tier-2	HI
<i>sodium chloride 0.45 % intravenous parenteral solution</i>	Tier-2	HI
<i>sodium chloride 0.9 % intravenous parenteral solution</i>	Tier-2	HI
<i>sodium chloride 3 %</i>	Tier-2	HI
<i>sodium chloride 5 %</i>	Tier-2	HI
<i>sodium lactate intravenous</i>	Tier-2	HI
IV NUTRITION		
AMINOSYN 8.5 %-ELECTROLYTES	Tier-3	B/D; HI
AMINOSYN II 10 %	Tier-3	B/D; HI
AMINOSYN II 15 %	Tier-3	B/D; HI
AMINOSYN II 7 % (OLD FORMULA)	Tier-3	B/D; HI
AMINOSYN II 8.5 %(OLD FORMULA)	Tier-3	B/D; HI
AMINOSYN II 8.5 %-ELECTROLYTES	Tier-3	B/D; HI
AMINOSYN M 3.5 %	Tier-3	B/D; HI
AMINOSYN-HBC 7%	Tier-3	B/D; HI
AMINOSYN-PF 10 %	Tier-3	B/D; HI
AMINOSYN-PF 7 % (SULFITE-FREE)	Tier-3	B/D; HI
CLINIMIX 5%/D15W SULFITE FREE	Tier-3	B/D; HI
CLINIMIX 5%/D25W SULFITE-FREE	Tier-3	B/D; HI
CLINIMIX 2.75%/D5W SULFIT FREE	Tier-3	B/D; HI
CLINIMIX 4.25%-D20W SULF-FREE	Tier-3	B/D; HI
CLINIMIX 4.25%-D25W SULF-FREE	Tier-3	B/D; HI

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
CLINIMIX 4.25%/D10W SULF FREE	Tier-3	B/D; HI
CLINIMIX 4.25%/D5W SULFIT FREE	Tier-3	B/D; HI
CLINIMIX 5%-D20W(SULFITE-FREE)	Tier-3	B/D; HI
CLINIMIX E 2.75%/D10W SUL FREE	Tier-3	B/D; HI
CLINIMIX E 2.75%/D5W SULF FREE	Tier-3	B/D; HI
CLINIMIX E 4.25%/D25W SUL FREE	Tier-3	B/D; HI
CLINIMIX E 4.25%/D5W SULF FREE	Tier-3	B/D; HI
CLINIMIX E 5%/D15W SULFIT FREE	Tier-3	B/D; HI
CLINIMIX E 5%/D20W SULFIT FREE	Tier-3	B/D; HI
CLINIMIX E 5%/D25W SULFIT FREE	Tier-3	B/D; HI
CLINISOL SF 15 %	Tier-3	B/D; HI
HEPATAMINE 8%	Tier-3	B/D; HI
INTRALIPID INTRAVENOUS EMULSION 20 %, 30 %	Tier-3	B/D; HI
NEPHRAMINE 5.4 %	Tier-3	B/D; HI
PREMASOL 10 %	Tier-3	B/D; HI
PREMASOL 6 %	Tier-3	B/D; HI
PROCALAMINE 3%	Tier-3	B/D; HI
PROSOL 20 %	Tier-3	B/D; HI
<i>tpn electrolytes</i>	Tier-2	B/D; HI
TRAVASOL 10 %	Tier-3	B/D; HI
TROPHAMINE 10 %	Tier-3	B/D; HI
TROPHAMINE 6%	Tier-3	B/D; HI
HORMONES		
ADRENAL CORTICOSTEROIDS		
<i>a-hydrocort</i>	Tier-2	
<i>cortisone</i>	Tier-2	
DEPO-MEDROL	Tier-3	
<i>dexamethasone oral elixir</i>	Tier-2	
<i>dexamethasone oral tablet</i>	Tier-1	
<i>dexamethasone intensol</i>	Tier-2	
<i>dexamethasone sodium phosphate injection solution 10 mg/ml</i>	Tier-2	
<i>dexpak 13 day</i>	Tier-2	
ELIGARD	Tier-3	
FIRMAGON	Tier-3	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
<i>fludrocortisone</i>	Tier-2	
<i>hydrocortisone oral</i>	Tier-2	
<i>methylprednisolone</i>	Tier-2	Transplant
<i>methylprednisolone acetate</i>	Tier-2	
<i>methylprednisolone sodium succ injection recon soln 125 mg, 40 mg</i>	Tier-2	
<i>methylprednisolone sodium succ intravenous</i>	Tier-2	Transplant
MILLIPRED	Tier-4	Transplant
ORAPRED	Tier-4	Transplant
ORAPRED ODT ORAL TABLET,DISINTEGRATING 15 MG, 30 MG	Tier-4	Transplant
<i>prednisolone sodium phosphate ophthalmic</i>	Tier-2	
<i>prednisolone sodium phosphate oral solution 15 mg/5 ml, 25 mg/5 ml (5 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)</i>	Tier-2	Transplant
<i>prednisone oral solution</i>	Tier-2	Transplant
<i>prednisone oral tablet</i>	Tier-1	Transplant
PREDNISON INTENSOL	Tier-4	Transplant
SOLU-CORTEF (PF) INJECTION RECON SOLN 100 MG/2 ML, 250 MG/2 ML	Tier-4	
SOLU-MEDROL (PF) INJECTION	Tier-4	Transplant
SOLU-MEDROL (PF) INTRAVENOUS RECON SOLN 500 MG/4 ML	Tier-4	Transplant
<i>triamcinolone acetonide injection</i>	Tier-2	
VERIPRED 20	Tier-4	Transplant
ANDROGENS		
ANDROGEL TRANSDERMAL GEL IN METERED-DOSE PUMP 20.25 MG/1.25 GRAM (1.62 %)	Tier-3	
ANDROGEL TRANSDERMAL GEL IN PACKET 1 % (50 MG/5 GRAM)	Tier-3	
ANDROXY	Tier-4	
<i>danazol oral</i>	Tier-2	
DEPO-TESTOSTERONE	Tier-4	
METHITEST	Tier-4	
<i>oxandrolone</i>	Tier-2	
STRIANT	Tier-4	
<i>testosterone cypionate</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
<i>testosterone enanthate</i>	Tier-2	
TESTRED	Tier-4	
GONADOTROPIN RELEASING AGONISTS		
LUPRON DEPOT INTRAMUSCULAR SYRINGE KIT 3.75 MG	Tier-3	
LUPRON DEPOT (3 MONTH) INTRAMUSCULAR SYRINGE KIT 22.5 MG	Tier-3	
LUPRON DEPOT (4 MONTH)	Tier-3	
LUPRON DEPOT (6 MONTH)	Tier-3	
LUPRON DEPOT-PED	Tier-3	
LUPRON DEPOT-PED (3 MONTH) INTRAMUSCULAR SYRINGE KIT 11.25 MG	Tier-3	
SYNAREL	Tier-3	
THYROID REPLACEMENT AND ANTITHYROID AGENTS		
<i>levothroid</i>	Tier-1	
<i>levothyroxine intravenous recon soln 100 mcg</i>	Tier-2	
<i>levothyroxine oral</i>	Tier-1	
<i>levoxyl oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 50 mcg, 75 mcg, 88 mcg</i>	Tier-1	
<i>liothyronine oral</i>	Tier-2	
<i>methimazole oral tablet 10 mg, 5 mg</i>	Tier-2	
<i>propylthiouracil</i>	Tier-2	
SYNTHROID	Tier-4	
THYROLAR-1	Tier-4	
THYROLAR-1/2	Tier-4	
THYROLAR-1/4	Tier-4	
THYROLAR-2	Tier-4	
THYROLAR-3	Tier-4	
TIROSINT	Tier-4	
<i>unithroid oral tablet 100 mcg, 112 mcg, 125 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg</i>	Tier-1	
IMMUNOLOGIC AGENTS		
IMMUNE STIMULANTS		
ACTHIB (PF)	Tier-3	
ACTIMMUNE	Tier-5	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
ADACEL(TDAP ADOLESN/ADULT)(PF) INTRAMUSCULAR SUSPENSION	Tier-3	
ADAGEN	Tier-5	
AFLURIA 2011-2012	Tier-3	* Part B
AFLURIA 2011-2012 (PF)	Tier-3	* Part B
<i>bcg vaccine, live (pf)</i>	Tier-2	
BIVIGAM	Tier-3	PA
BOOSTRIX TDAP	Tier-3	
CARIMUNE NF NANOFILTERED INTRAVENOUS RECON SOLN 6 GRAM	Tier-3	PA; HI; Part B
CERVARIX VACCINE (PF)	Tier-3	
COMVAX (PF)	Tier-3	
DAPTACEL (DTAP PEDIATRIC) (PF)	Tier-3	
DECAVAC (PF) INTRAMUSCULAR SYRINGE	Tier-3	
ENGERIX-B (PF) INTRAMUSCULAR SYRINGE	Tier-3	B/D
ENGERIX-B PEDIATRIC (PF)	Tier-3	B/D
FLUARIX 2011-2012 (PF)	Tier-3	* Part B
FLULAVAL 2011-2012	Tier-3	* Part B
FLUVIRIN 2011-2012	Tier-3	* Part B
FLUVIRIN 2011-2012 (PF)	Tier-3	* Part B
FLUZONE 2011-2012	Tier-3	* Part B
FLUZONE 2011-2012 (PF)	Tier-3	* Part B
FLUZONE HIGH-DOSE 2011-12 (PF)	Tier-3	* Part B
FLUZONE INTRADERM 2011-12 (PF)	Tier-3	* Part B
FOSAMAX ORAL SOLUTION	Tier-3	
GAMASTAN S/D	Tier-3	PA
GAMMAGARD LIQUID	Tier-3	PA; HI; Part B
GAMMAPLEX	Tier-3	PA; HI; Part B
GAMUNEX-C INJECTION SOLUTION 1 GRAM/10 ML (10 %)	Tier-3	PA; HI; Part B
GARDASIL (PF)	Tier-3	
GRASTEK	Tier-4	PA
HAVRIX (PF) INTRAMUSCULAR SUSPENSION 1,440 ELISA UNIT/ML	Tier-3	
HAVRIX (PF) INTRAMUSCULAR SYRINGE 720 ELISA UNIT/0.5 ML	Tier-3	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
HIBERIX (PF)	Tier-3	
IMOVAX RABIES VACCINE (PF)	Tier-3	
INFANRIX (DTAP) (PF) INTRAMUSCULAR SUSPENSION	Tier-3	
IPOL INJECTION SUSPENSION	Tier-3	
IXIARO (PF)	Tier-3	
M-M-R II (PF)	Tier-3	
MENACTRA (PF) INTRAMUSCULAR SOLUTION	Tier-3	
MENOMUNE - A/C/Y/W-135 (PF)	Tier-3	
MENVEO A-C-Y-W-135-DIP (PF)	Tier-3	
PEDVAX HIB (PF)	Tier-3	
<i>pneumovax 23 injection injectable</i>	Tier-3	
<i>prevnar 13 (pf)</i>	Tier-3	
PRIVIGEN	Tier-3	PA; HI; Part B
PROQUAD (PF)	Tier-3	
RABAVERT (PF)	Tier-3	
RAGWITEK	Tier-4	PA
RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION 10 MCG/ML, 40 MCG/ML	Tier-3	B/D
RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE	Tier-3	B/D
ROTATEQ VACCINE	Tier-3	
<i>tetanus toxoid,adsorbed (pf)</i>	Tier-2	
<i>tetanus-diphtheria toxoids-td</i>	Tier-2	
THYMOGLOBULIN	Tier-3	PA; HI
TWINRIX (PF) INTRAMUSCULAR SUSPENSION	Tier-3	
TYPHIM VI INTRAMUSCULAR SOLUTION	Tier-3	
VAQTA (PF) INTRAMUSCULAR SUSPENSION 25 UNIT/0.5 ML	Tier-3	
VAQTA (PF) INTRAMUSCULAR SYRINGE	Tier-3	
VARIVAX (PF)	Tier-3	
VIVOTIF BERNA VACCINE	Tier-3	
YF-VAX (PF)	Tier-3	
ZOSTAVAX (PF)	Tier-3	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
IMMUNOSUPPRESSIVES		
ASTAGRAF XL	Tier-4	B/D
BENLYSTA INTRAVENOUS RECON SOLN 120 MG	Tier-3	PA
CELLCEPT ORAL SUSPENSION FOR RECONSTITUTION	Tier-4	B/D
<i>cyclosporine oral capsule</i>	Tier-2	B/D
<i>cyclosporine modified</i>	Tier-2	B/D
<i>gengraf</i>	Tier-2	B/D
ILARIS (PF)	Tier-3	PA
<i>mycophenolate mofetil oral capsule</i>	Tier-2	B/D
<i>mycophenolate mofetil oral tablet</i>	Tier-2	B/D
<i>mycophenolate sodium</i>	Tier-2	B/D
MYFORTIC	Tier-4	B/D
NULOJIX	Tier-3	B/D
RAPAMUNE	Tier-3	B/D
SIMULECT INTRAVENOUS RECON SOLN 20 MG	Tier-5	B/D
<i>sirolimus oral tablet 0.5 mg</i>	Tier-2	B/D
<i>tacrolimus oral capsule 0.5 mg, 1 mg</i>	Tier-2	B/D
<i>tacrolimus oral capsule 5 mg</i>	Tier-5	B/D
ZORTRESS	Tier-3	B/D; QL (180 EA per 90 days)
MISCELLANEOUS DRUGS		
ACROMEGALY		
<i>octreotide acetate injection solution</i>	Tier-2	
SANDOSTATIN	Tier-3	
SANDOSTATIN LAR DEPOT	Tier-5	
SOMATULINE DEPOT	Tier-3	
SOMAVERT SUBCUTANEOUS RECON SOLN 10 MG, 15 MG, 20 MG	Tier-5	PA
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION	Tier-3	
TRELSTAR INTRAMUSCULAR SYRINGE 11.25 MG/2 ML, 3.75 MG/2 ML	Tier-3	
AMYOTROPHIC LATERAL SCLEROSIS		
RILUTEK	Tier-5	
<i>riluzole</i>	Tier-3	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
ANAPHYLAXIS EMERGENCY		
AUVI-Q	Tier-3	QL (2 EA per 7 Days)
<i>epinephrine injection syringe 0.1 mg/ml (1:10,000)</i>	Tier-2	QL (2 ML per 1 Day)
EPIPEN 2-PAK	Tier-3	QL (2 EA per 7 days)
EPIPEN JR 2-PAK	Tier-3	QL (2 EA per 7 days)
<i>midodrine</i>	Tier-2	
TWINJECT AUTOINJECTOR	Tier-3	QL (2 EA per 7 Days)
CASTLEMAN DISEASE		
SYLVANT INTRAVENOUS RECON SOLN 100 MG	Tier-3	PA
CRYOPYRIN-ASSOCIATED PERIODIC SYNDROMES		
ARCALYST	Tier-3	PA
CUSHING DISEASE		
SIGNIFOR	Tier-5	PA; QL (60 ML per 30 days)
CYSTIC FIBROSIS		
BETHKIS	Tier-5	
CAYSTON	Tier-5	
KALYDECO	Tier-5	PA; QL (60 EA per 30 days)
PULMOZYME	Tier-5	
TOBI	Tier-5	
TOBI PODHALER INHALATION CAPSULE, W/INHALATION DEVICE	Tier-5	
<i>tobramycin in 0.225 % nacl</i>	Tier-2	
CYSTINURIA		
CYSTADANE	Tier-3	
DETOXIFICATION AGENTS		
CHEMET	Tier-4	
EXJADE	Tier-3	
FABRY DISEASE		
FABRAZYME INTRAVENOUS RECON SOLN 35 MG	Tier-3	PA
GAUCHER DISEASE		
CEREZYME INTRAVENOUS RECON SOLN 200 UNIT	Tier-3	PA
ELELYSO	Tier-3	PA

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
VPRIV	Tier-3	PA
ZAVESCA	Tier-5	PA
GROWTH HORMONE DEFICIENCY		
EGRIFTA SUBCUTANEOUS RECON SOLN 2 MG	Tier-5	PA
GENOTROPIN	Tier-3	PA
GENOTROPIN MINIQUICK	Tier-3	PA
HUMATROPE	Tier-3	PA
INCRELEX	Tier-5	PA
NORDITROPIN FLEXPPO	Tier-5	PA
NORDITROPIN NORDIFLEX	Tier-5	PA
NUTROPIN SUBCUTANEOUS RECON SOLN 10 MG	Tier-5	PA
NUTROPIN AQ	Tier-5	PA
NUTROPIN AQ NUSPIN SUBCUTANEOUS CARTRIDGE 5 MG/2 ML (2.5 MG/ML)	Tier-5	PA
OMNITROPE	Tier-3	PA
SAIZEN SUBCUTANEOUS RECON SOLN 5 MG	Tier-5	PA
SAIZEN CLICK.EASY	Tier-5	PA
SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG	Tier-5	PA
TEV-TROPIN	Tier-5	PA
ZORBTIVE	Tier-5	PA
HEREDITARY ANGIOEDEMA		
CINRYZE	Tier-3	PA
FIRAZYR	Tier-5	PA; QL (3 ML per 7 days)
HEREDITARY TYROSINEMIA TYPE 2		
ORFADIN	Tier-5	PA
HUNTINGTON DISEASE		
XENAZINE ORAL TABLET 12.5 MG	Tier-5	PA; QL (90 EA per 30 days)
XENAZINE ORAL TABLET 25 MG	Tier-5	PA; QL (120 EA per 30 days)
HYPERCALCEMIA		
HECTOROL ORAL	Tier-3	
SENSIPAR	Tier-3	
HYPERPARATHYROIDISM		
<i>calcitriol oral</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
<i>doxercalciferol</i>	Tier-2	
<i>paricalcitol oral</i>	Tier-2	
ZEMPLAR ORAL	Tier-3	
MUCOPOLYSACCHARIDOSIS		
ALDURAZYME	Tier-3	
ELAPRASE	Tier-3	
LUMIZYME	Tier-3	
NAGLAZYME	Tier-3	
TYSABRI	Tier-5	PA; LA
MULTIPLE SCLEROSIS		
AMPYRA	Tier-3	PA; QL (60 EA per 30 days)
AUBAGIO	Tier-5	PA; QL (30 EA per 30 Days)
AVONEX INTRAMUSCULAR KIT	Tier-5	QL (4 EA per 30 days)
AVONEX INTRAMUSCULAR SYRINGE KIT	Tier-5	QL (4 EA per 30 days)
BETASERON SUBCUTANEOUS KIT	Tier-5	QL (15 EA per 30 days)
COPAXONE SUBCUTANEOUS SYRINGE KIT	Tier-5	QL (30 EA per 30 Days)
EXTAVIA SUBCUTANEOUS KIT	Tier-5	QL (15 EA per 30 days)
GILENYA	Tier-5	PA; QL (30 EA per 30 Days)
REBIF (WITH ALBUMIN)	Tier-5	QL (11 ML per 30 days)
REBIF TITRATION PACK	Tier-5	QL (12 ML per 30 days)
TECFIDERA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 120 MG, 240 MG	Tier-5	PA; QL (60 EA per 30 Days)
TECFIDERA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 120 MG (14)- 240 MG (46)	Tier-5	PA; QL (1 EA per 30 days)
MYASTHENIA GRAVIS		
<i>guanidine</i>	Tier-2	
MESTINON ORAL SYRUP	Tier-4	
MESTINON TIMESPAN	Tier-3	
MYTELASE	Tier-4	
<i>pyridostigmine bromide</i>	Tier-2	
PAGET'S DISEASE		
<i>etidronate disodium</i>	Tier-2	
PHENYLKETONURIA		
KUVAN ORAL TABLET,SOLUBLE	Tier-5	PA
PHOSPHATE BINDERS		
<i>calcium acetate oral capsule</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
FOSRENOL	Tier-3	
PHOSLYRA	Tier-3	
RENAGEL	Tier-3	
RENVELA	Tier-3	
VELPHORO	Tier-4	
POMPE DISEASE		
MYOZYME	Tier-3	
POTASSIUM BINDER		
<i>kionex oral powder</i>	Tier-2	
<i>sodium polystyrene (sorb free)</i>	Tier-2	
PULMONARY HYPERTENSION		
ADCIRCA	Tier-5	PA; QL (60 EA per 30 days)
ADEMPAS	Tier-5	PA
FLOLAN	Tier-3	PA
LETAIRIS	Tier-5	PA
OPSUMIT	Tier-5	PA
REMODULIN	Tier-3	PA
REVATIO INTRAVENOUS	Tier-3	PA
SILDENAFIL	Tier-3	PA; QL (90 EA per 30 days)
TRACLEER	Tier-5	PA; LA
VELETRI	Tier-3	PA
RESPIRATORY SYNCYTIAL VIRUS		
SYNAGIS INTRAMUSCULAR SOLUTION 50 MG/0.5 ML	Tier-3	
SMOKING CESSATION		
<i>buproban</i>	Tier-2	
CHANTIX	Tier-4	QL (60 EA per 30 days)
CHANTIX STARTING MONTH BOX	Tier-4	QL (53 EA per 30 days)
NICOTROL	Tier-3	
NICOTROL NS	Tier-4	
SYMPTOMATIC BENIGN PROSTATIC HYPERPLASIA		
<i>alfuzosin</i>	Tier-2	
AVODART	Tier-3	
CIALIS ORAL TABLET 2.5 MG, 5 MG	Tier-4	PA; QL (30 EA per 30 days)
<i>finasteride oral tablet 5 mg</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
JALYN	Tier-3	
<i>tamsulosin</i>	Tier-2	
UROLOGIC DISORDERS		
<i>bethanechol chloride</i>	Tier-2	
<i>desmopressin injection</i>	Tier-2	
<i>desmopressin nasal spray,non-aerosol</i>	Tier-2	
<i>desmopressin oral</i>	Tier-2	
DETROL LA	Tier-4	STPA
ELMIRON	Tier-4	
ENABLEX	Tier-4	STPA
<i>flavoxate</i>	Tier-2	
GELNIQUE	Tier-3	
LITHOSTAT	Tier-4	
MYRBETRIQ	Tier-4	STPA
<i>oxybutynin chloride oral syrup</i>	Tier-2	
<i>oxybutynin chloride oral tablet</i>	Tier-1	
<i>oxybutynin chloride oral tablet extended release 24hr</i>	Tier-2	
OXYTROL	Tier-3	
<i>potassium citrate</i>	Tier-2	
SAMSCA	Tier-4	
<i>tolterodine</i>	Tier-3	
<i>trospium</i>	Tier-2	
UROCIT-K 10	Tier-4	
UROCIT-K 15	Tier-4	
UROCIT-K 5	Tier-4	
VESICARE	Tier-3	
WILSON'S DISEASE		
DEPEN TITRATABS	Tier-3	
SYPRINE	Tier-3	
NEUROLOGICAL DRUGS		
ALZHEIMERS DISEASE		
<i>donepezil</i>	Tier-2	
<i>ergoloid</i>	Tier-2	
EXELON TRANSDERMAL	Tier-4	
<i>galantamine</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
NAMENDA	Tier-3	
NAMENDA TITRATION PAK	Tier-3	
NAMENDA XR	Tier-3	
<i>rivastigmine tartrate</i>	Tier-2	
MIGRAINE THERAPY		
<i>butalbital-acetaminop-caf-cod oral capsule 50-325-40-30 mg</i>	Tier-2	QL (360 EA per 30 days)
<i>dihydroergotamine injection</i>	Tier-2	
MIGERGOT	Tier-3	
MIGRANAL	Tier-4	QL (12 ML per 30 Days)
<i>naratriptan</i>	Tier-2	QL (9 EA per 30 days)
<i>rizatriptan</i>	Tier-2	QL (12 EA per 30 Days)
<i>sumatriptan</i>	Tier-2	QL (8 EA per 30 days)
<i>sumatriptan succinate oral</i>	Tier-2	QL (9 EA per 30 days)
<i>sumatriptan succinate subcutaneous pen injector 6 mg/0.5 ml</i>	Tier-2	QL (4 ML per 30 Days)
<i>sumatriptan succinate subcutaneous solution</i>	Tier-2	QL (8 ML per 30 Days)
SUMAVEL DOSEPRO SUBCUTANEOUS NEEDLE-FREE INJECTOR 6 MG/0.5 ML	Tier-4	QL (4 ML per 30 days)
<i>zolmitriptan</i>	Tier-2	QL (6 EA per 30 days)
PARKINSONS DISEASE		
APOKYN	Tier-5	
AZILECT	Tier-3	
<i>benztropine oral</i>	Tier-1	
<i>bromocriptine</i>	Tier-2	
<i>cabergoline</i>	Tier-2	
<i>carbidopa</i>	Tier-2	
<i>carbidopa-levodopa</i>	Tier-2	
<i>carbidopa-levodopa-entacapone</i>	Tier-2	
CYCLOSET	Tier-3	
<i>entacapone</i>	Tier-2	
LODOSYN	Tier-3	
MIRAPEX ER	Tier-4	
NEUPRO	Tier-4	QL (30 EA per 30 days)
<i>pramipexole</i>	Tier-2	
<i>ropinirole</i>	Tier-2	
<i>selegiline hcl</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
STALEVO 100	Tier-3	
STALEVO 125	Tier-3	
STALEVO 150	Tier-3	
STALEVO 200	Tier-3	
STALEVO 50	Tier-3	
STALEVO 75	Tier-3	
TASMAR ORAL TABLET 100 MG	Tier-3	
<i>trihexyphenidyl</i>	Tier-1	
PSEUDOBLBAR AFFECT		
NUEDEXTA	Tier-3	PA
SEIZURES		
APTIOM	Tier-4	PA
BANZEL ORAL SUSPENSION	Tier-3	QL (2400 ML per 30 days)
BANZEL ORAL TABLET 200 MG	Tier-3	QL (1440 EA per 90 days)
BANZEL ORAL TABLET 400 MG	Tier-3	QL (720 EA per 90 days)
<i>carbamazepine oral capsule, er multiphase 12 hr</i>	Tier-2	
<i>carbamazepine oral suspension 100 mg/5 ml</i>	Tier-2	
<i>carbamazepine oral tablet</i>	Tier-1	
<i>carbamazepine oral tablet extended release 12 hr</i>	Tier-2	
<i>carbamazepine oral tablet, chewable</i>	Tier-2	
CELONTIN ORAL CAPSULE 300 MG	Tier-4	
<i>clonazepam</i>	Tier-2	
<i>diazepam oral solution 5 mg/5 ml</i>	Tier-2	
<i>diazepam oral tablet</i>	Tier-2	
<i>diazepam rectal</i>	Tier-2	
<i>diazepam intensol</i>	Tier-2	
DILANTIN	Tier-3	
DILANTIN INFATABS	Tier-3	
<i>divalproex</i>	Tier-2	
<i>epitol</i>	Tier-1	
<i>ethosuximide</i>	Tier-2	
<i>felbamate</i>	Tier-2	
FYCOMPA	Tier-4	PA
<i>gabapentin oral capsule</i>	Tier-2	
<i>gabapentin oral solution 250 mg/5 ml</i>	Tier-2	
<i>gabapentin oral tablet 600 mg, 800 mg</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
GABITRIL	Tier-3	
HORIZANT	Tier-4	QL (60 EA per 30 Days)
LAMICTAL ODT	Tier-4	
<i>lamotrigine oral tablet</i>	Tier-2	
<i>lamotrigine oral tablet extended release 24hr</i>	Tier-3	
<i>lamotrigine oral tablet, chewable dispersible</i>	Tier-2	
<i>levetiracetam intravenous</i>	Tier-2	
<i>levetiracetam oral solution 100 mg/ml</i>	Tier-2	
<i>levetiracetam oral tablet</i>	Tier-2	
<i>levetiracetam oral tablet extended release 24 hr</i>	Tier-2	
LYRICA	Tier-4	STPA
ONFI ORAL SUSPENSION	Tier-4	
ONFI ORAL TABLET 10 MG, 20 MG	Tier-4	QL (60 EA per 30 days)
<i>oxcarbazepine</i>	Tier-2	
OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HR 150 MG, 300 MG	Tier-4	QL (30 EA per 30 Days)
OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HR 600 MG	Tier-4	QL (120 EA per 30 Days)
PEGANONE	Tier-4	
<i>phenobarbital</i>	Tier-2	
<i>phenytoin oral suspension 125 mg/5 ml</i>	Tier-2	
<i>phenytoin oral tablet, chewable</i>	Tier-2	
<i>phenytoin sodium intravenous solution</i>	Tier-2	
<i>phenytoin sodium extended</i>	Tier-2	
POTIGA	Tier-4	PA
<i>primidone</i>	Tier-2	
QUDEXY XR	Tier-4	
SABRIL	Tier-5	
SAVELLA ORAL TABLET	Tier-3	STPA; QL (180 EA per 90 days)
STAVZOR	Tier-4	
TEGRETOL XR ORAL TABLET EXTENDED RELEASE 12 HR 100 MG	Tier-3	
<i>tiagabine</i>	Tier-2	
<i>topiramate oral capsule, sprinkle</i>	Tier-2	
<i>topiramate oral tablet</i>	Tier-2	
TROKENDI XR	Tier-4	
<i>valproic acid</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
<i>valproic acid (as sodium salt) oral solution 250 mg/5 ml</i>	Tier-2	
VIMPAT INTRAVENOUS	Tier-4	
VIMPAT ORAL SOLUTION	Tier-4	PA; QL (1200 ML per 30 days)
VIMPAT ORAL TABLET	Tier-4	PA; QL (180 EA per 90 days)
<i>zonisamide</i>	Tier-2	
SPASTICITY		
<i>baclofen</i>	Tier-1	
<i>cyclobenzaprine oral capsule, extended release 24hr</i>	Tier-2	
<i>cyclobenzaprine oral tablet</i>	Tier-1	
<i>dantrolene</i>	Tier-2	
<i>tizanidine</i>	Tier-2	
PAIN AND INFLAMMATORY DISEASES		
ARTHRITIS		
ACTEMRA INTRAVENOUS SOLUTION 200 MG/10 ML (20 MG/ML)	Tier-3	PA
ACTEMRA SUBCUTANEOUS	Tier-3	PA
ARTHROTEC 50	Tier-4	
ARTHROTEC 75	Tier-4	
AZASAN	Tier-4	B/D
<i>azathioprine</i>	Tier-2	B/D
CELEBREX	Tier-4	PA
CIMZIA	Tier-5	PA; QL (2 EA per 30 days)
CIMZIA POWDER FOR RECONST	Tier-3	PA
<i>diclofenac potassium</i>	Tier-1	
<i>diclofenac sodium oral</i>	Tier-1	
<i>diclofenac sodium topical</i>	Tier-2	
<i>diclofenac-misoprostol</i>	Tier-2	
ENBREL SUBCUTANEOUS RECON SOLN	Tier-5	PA; QL (8 EA per 28 Days)
ENBREL SUBCUTANEOUS SYRINGE 25 MG/0.5ML (0.51)	Tier-5	PA; QL (8.16 ML per 28 Days)
ENBREL SUBCUTANEOUS SYRINGE 50 MG/ML (0.98 ML)	Tier-5	PA; QL (7.84 ML per 28 Days)
<i>fenoprofen oral tablet</i>	Tier-2	
<i>flurbiprofen</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
HUMIRA SUBCUTANEOUS SYRINGE KIT 20 MG/0.4 ML, 40 MG/0.8 ML	Tier-5	PA; QL (6 EA per 30 days)
HUMIRA CROHN'S DIS START PCK	Tier-5	PA; QL (6 EA per 365 Days)
INDOCIN ORAL	Tier-4	
<i>indomethacin oral</i>	Tier-1	
KINERET	Tier-5	PA; QL (20.1 ML per 30 days)
<i>leflunomide</i>	Tier-2	
<i>meclofenamate oral</i>	Tier-2	
<i>meloxicam</i>	Tier-1	
<i>methotrexate sodium oral</i>	Tier-2	B/D
<i>nabumetone</i>	Tier-2	
NALFON ORAL CAPSULE 400 MG	Tier-4	
ORENCIA	Tier-3	PA; QL (4 ML per 28 Days)
ORENCIA (WITH MALTOSE)	Tier-3	PA
OTEZLA	Tier-5	PA; QL (60 EA per 30 days)
OTEZLA STARTER	Tier-5	PA; QL (27 EA per 365 days)
OTREXUP (PF)	Tier-4	
PENNSAID	Tier-4	
<i>piroxicam</i>	Tier-2	
REMICADE	Tier-3	PA
RIDAURA	Tier-3	
SIMPONI SUBCUTANEOUS SYRINGE 100 MG/ML	Tier-5	PA; QL (1 ML per 28 days)
SIMPONI SUBCUTANEOUS SYRINGE 50 MG/0.5 ML	Tier-5	PA; QL (0.5 ML per 28 Days)
SIMPONI ARIA	Tier-5	PA
<i>sulindac oral</i>	Tier-2	
<i>tolmetin</i>	Tier-2	
TREXALL	Tier-4	B/D
VOLTAREN TOPICAL	Tier-4	
XELJANZ	Tier-5	PA; QL (60 EA per 30 days)
GOUT		
<i>allopurinol</i>	Tier-1	
<i>colchicine-probenecid</i>	Tier-2	
COLCRYS	Tier-3	QL (120 EA per 30 Days)
<i>probenecid</i>	Tier-2	
ULORIC	Tier-4	STPA

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
PAIN, NSAID ANALGESICS		
<i>diflunisal</i>	Tier-2	
<i>etodolac</i>	Tier-2	
<i>ibuprofen oral suspension</i>	Tier-2	
<i>ibuprofen oral tablet 400 mg, 600 mg, 800 mg</i>	Tier-1	
<i>ketoprofen oral capsule</i>	Tier-2	
<i>ketoprofen oral capsule,ext rel. pellets 24 hr 200 mg</i>	Tier-2	
<i>mefenamic acid</i>	Tier-2	
<i>naproxen oral suspension</i>	Tier-2	
<i>naproxen oral tablet</i>	Tier-1	
<i>naproxen oral tablet,delayed release (dr/ec)</i>	Tier-1	
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	Tier-1	
PAIN, OPIOID AND OTHER ANALGESICS		
ABSTRAL	Tier-4	QL (32 EA per 30 days)
<i>acetaminophen-codeine oral solution 300 mg-30 mg /12.5 ml</i>	Tier-2	QL (5000 ML per 30 days)
<i>acetaminophen-codeine oral tablet 300-15 mg</i>	Tier-2	QL (300 EA per 30 days)
<i>acetaminophen-codeine oral tablet 300-30 mg, 300-60 mg</i>	Tier-2	QL (400 EA per 30 days)
<i>butorphanol tartrate nasal</i>	Tier-2	QL (7.5 ML per 30 days)
BUTRANS TRANSDERMAL PATCH WEEKLY 10 MCG/HOUR, 15 MCG/HOUR, 20 MCG/HOUR, 5 MCG/HOUR	Tier-4	QL (4 EA per 28 Days)
<i>codeine sulfate oral tablet</i>	Tier-2	QL (180 EA per 30 days)
DILAUDID ORAL LIQUID	Tier-4	QL (1440 ML per 30 days)
<i>endocet oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	Tier-2	QL (360 EA per 30 days)
<i>endodan</i>	Tier-2	QL (360 EA per 30 days)
<i>fentanyl</i>	Tier-2	QL (10 EA per 30 days)
<i>fentanyl citrate</i>	Tier-2	QL (120 EA per 30 days)
<i>hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml</i>	Tier-2	QL (5540 ML per 30 days)
<i>hydrocodone-acetaminophen oral tablet 10-300 mg, 5-300 mg, 7.5-300 mg</i>	Tier-2	QL (400 EA per 30 days)
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	Tier-2	QL (360 EA per 30 days)
<i>hydrocodone-ibuprofen oral tablet 7.5-200 mg</i>	Tier-2	QL (480 EA per 30 days)

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
<i>hydromorphone oral tablet</i>	Tier-2	QL (360 EA per 30 days)
<i>hydromorphone oral tablet extended release 24 hr 12 mg, 16 mg, 8 mg</i>	Tier-2	QL (30 EA per 30 days)
<i>ibuprofen-oxycodone</i>	Tier-2	QL (240 EA per 30 days)
LAZANDA	Tier-4	QL (30 EA per 30 Days)
<i>levorphanol tartrate</i>	Tier-2	QL (240 EA per 30 days)
<i>methadone oral solution 10 mg/5 ml</i>	Tier-2	QL (1800 ML per 30 days)
<i>methadone oral solution 5 mg/5 ml</i>	Tier-2	QL (3600 ML per 30 days)
<i>methadone oral tablet</i>	Tier-2	QL (120 EA per 30 days)
<i>morphine oral capsule, er multiphase 24 hr 120 mg, 30 mg, 45 mg, 60 mg, 75 mg</i>	Tier-2	QL (60 EA per 30 days)
<i>morphine oral capsule, er multiphase 24 hr 90 mg</i>	Tier-2	
<i>morphine oral capsule, extend. release pellets</i>	Tier-2	QL (90 EA per 30 Days)
<i>morphine oral solution</i>	Tier-2	QL (480 ML per 30 Days)
<i>morphine oral tablet</i>	Tier-2	QL (180 EA per 30 days)
<i>morphine oral tablet extended release</i>	Tier-2	QL (90 EA per 30 days)
<i>morphine concentrate oral solution</i>	Tier-2	QL (480 ML per 30 Days)
<i>oxycodone oral capsule</i>	Tier-2	QL (360 EA per 30 days)
<i>oxycodone oral concentrate</i>	Tier-2	QL (120 ML per 30 days)
<i>oxycodone oral solution</i>	Tier-2	QL (2400 ML per 30 Days)
<i>oxycodone oral tablet 10 mg, 15 mg, 20 mg, 30 mg</i>	Tier-2	QL (180 EA per 30 days)
<i>oxycodone oral tablet 5 mg</i>	Tier-2	QL (360 EA 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	QL (360 EA per 30 days)
<i>oxycodone-aspirin</i>	Tier-2	QL (360 EA per 30 days)
OXYCONTIN	Tier-3	QL (120 EA per 30 days)
<i>oxymorphone oral tablet</i>	Tier-2	QL (180 EA per 30 days)
<i>oxymorphone oral tablet extended release 12 hr</i>	Tier-2	QL (60 EA per 30 Days)
ROXICET ORAL SOLUTION	Tier-4	QL (1850 ML per 30 days)
SUBSYS SUBLINGUAL SPRAY, NON-AEROSOL 100 MCG/SPRAY, 200 MCG/SPRAY, 400 MCG/SPRAY, 600 MCG/SPRAY, 800 MCG/SPRAY	Tier-4	QL (120 EA per 30 days)
<i>tramadol oral tablet</i>	Tier-2	
<i>tramadol oral tablet extended release 24 hr 100 mg, 200 mg</i>	Tier-2	
<i>tramadol oral tablet, er multiphase 24 hr 300 mg</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
<i>tramadol-acetaminophen</i>	Tier-2	QL (360 EA per 30 days)
XARTEMIS XR	Tier-4	QL (120 EA per 30 days)
PSYCHIATRIC		
ALCOHOL DETERRENTS		
<i>acamprosate</i>	Tier-2	
CAMPRAL	Tier-3	
<i>disulfiram</i>	Tier-2	
<i>naltrexone oral</i>	Tier-2	
ANXIETY		
<i>alprazolam</i>	Tier-2	
<i>alprazolam intensol</i>	Tier-2	
<i>amitriptyline-chlordiazepoxide</i>	Tier-2	
<i>buspirone</i>	Tier-1	
<i>clorazepate dipotassium</i>	Tier-2	
<i>lorazepam oral tablet</i>	Tier-2	
<i>lorazepam intensol</i>	Tier-2	
<i>meprobamate</i>	Tier-2	
<i>oxazepam</i>	Tier-2	
ATTENTION DEFICIT DISORDER		
ADDERALL XR	Tier-4	STPA
<i>amphetamine salt combo</i>	Tier-2	
<i>clonidine hcl oral tablet extended release 12 hr</i>	Tier-2	
DAYTRANA	Tier-3	STPA
DESOXYN	Tier-4	
<i>dexedrine</i>	Tier-2	
DEXEDRINE SPANSULE	Tier-4	
<i>dexmethylphenidate oral capsule,er biphasic 50-50 15 mg, 30 mg, 40 mg</i>	Tier-2	
<i>dexmethylphenidate oral tablet</i>	Tier-2	
<i>dextroamphetamine oral capsule, extended release</i>	Tier-2	
<i>dextroamphetamine oral tablet</i>	Tier-2	
<i>dextroamphetamine-amphetamine oral capsule,extended release 24hr</i>	Tier-2	
FOCALIN XR	Tier-3	STPA
INTUNIV ER	Tier-4	QL (90 EA per 90 days)
METADATE CD	Tier-4	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
METADATE ER	Tier-4	
<i>methamphetamine</i>	Tier-2	
METHYLIN ORAL SOLUTION	Tier-3	
METHYLIN ORAL TABLET,CHEWABLE	Tier-3	
<i>methylphenidate oral capsule, er biphasic 30-70 10 mg, 50 mg, 60 mg</i>	Tier-2	
<i>methylphenidate oral capsule,er biphasic 50-50</i>	Tier-2	
<i>methylphenidate oral solution</i>	Tier-2	
<i>methylphenidate oral tablet</i>	Tier-2	
<i>methylphenidate oral tablet extended release 20 mg</i>	Tier-2	
<i>methylphenidate oral tablet extended release 24hr</i>	Tier-2	
QUILLIVANT XR	Tier-4	STPA
STRATTERA ORAL CAPSULE 10 MG, 18 MG, 25 MG, 40 MG, 60 MG	Tier-3	QL (60 EA per 30 days)
STRATTERA ORAL CAPSULE 100 MG, 80 MG	Tier-3	QL (30 EA per 30 days)
VYVANSE	Tier-4	STPA
BIPOLAR DISORDER		
EQUETRO	Tier-4	
<i>lithium carbonate</i>	Tier-1	
<i>lithium citrate oral solution 8 meq/5 ml</i>	Tier-1	
<i>olanzapine-fluoxetine</i>	Tier-2	STPA
RISPERDAL CONSTA INTRAMUSCULAR SYRINGE 50 MG/2 ML	Tier-3	
<i>risperidone oral tablet,disintegrating</i>	Tier-2	
DEPRESSION		
<i>amitriptyline</i>	Tier-1	
<i>amoxapine</i>	Tier-2	
ALENZIN	Tier-4	STPA
BRINTELLIX	Tier-4	STPA
<i>budeprion sr oral tablet extended release 150 mg</i>	Tier-2	
<i>bupropion hcl</i>	Tier-2	
<i>citalopram</i>	Tier-1	
<i>clomipramine</i>	Tier-2	
CYMBALTA	Tier-4	STPA; QL (60 EA per 30 days)
<i>desipramine oral</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
DESVENLAFAXINE ORAL TABLET EXTENDED RELEASE 24 HR	Tier-3	
<i>doxepin oral capsule</i>	Tier-1	
<i>doxepin oral concentrate</i>	Tier-2	
<i>duloxetine oral capsule, delayed release(dr/ec) 20 mg, 60 mg</i>	Tier-3	QL (60 EA per 30 Days)
<i>duloxetine oral capsule, delayed release(dr/ec) 30 mg</i>	Tier-3	QL (90 EA per 30 days)
EMSAM	Tier-4	STPA
<i>escitalopram oxalate</i>	Tier-2	
FETZIMA	Tier-4	STPA
<i>fluoxetine oral capsule</i>	Tier-1	
<i>fluoxetine oral capsule, delayed release(dr/ec)</i>	Tier-1	
<i>fluoxetine oral solution</i>	Tier-2	
<i>fluoxetine oral tablet 10 mg, 20 mg</i>	Tier-1	
<i>fluoxetine oral tablet 60 mg</i>	Tier-2	
<i>fluvoxamine</i>	Tier-2	
<i>imipramine hcl</i>	Tier-2	
<i>imipramine pamoate</i>	Tier-2	
KHEDEZLA	Tier-4	STPA
LUVOX CR	Tier-4	STPA
<i>maprotiline</i>	Tier-2	
MARPLAN	Tier-4	
<i>mirtazapine</i>	Tier-2	
<i>nefazodone</i>	Tier-2	
<i>nortriptyline</i>	Tier-1	
OLEPTRO ER	Tier-4	STPA
<i>paroxetine hcl oral tablet</i>	Tier-1	
<i>paroxetine hcl oral tablet extended release 24 hr</i>	Tier-1	
PAXIL ORAL SUSPENSION	Tier-4	
PEXEVA	Tier-4	STPA
<i>phenelzine</i>	Tier-2	
<i>protriptyline</i>	Tier-2	
<i>sertraline</i>	Tier-2	
<i>tranylcypromine</i>	Tier-2	
<i>trazodone</i>	Tier-1	
<i>trimipramine</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
<i>venlafaxine oral capsule,extended release 24hr</i>	Tier-2	
<i>venlafaxine oral tablet</i>	Tier-2	
VENLAFAXINE ORAL TABLET EXTENDED RELEASE 24HR	Tier-4	STPA
VIIBRYD	Tier-4	STPA
VIVACTIL	Tier-4	
INSOMNIA		
<i>estazolam</i>	Tier-2	
<i>eszopiclone</i>	Tier-2	QL (30 EA per 30 days)
<i>flurazepam</i>	Tier-2	
HETLIOZ	Tier-4	PA
LUNESTA	Tier-4	STPA; QL (30 EA per 30 days)
ROZEREM	Tier-4	STPA; QL (30 EA per 30 days)
<i>temazepam</i>	Tier-2	
<i>triazolam</i>	Tier-2	
<i>zaleplon</i>	Tier-2	QL (30 EA per 30 days)
<i>zolpidem oral tablet</i>	Tier-2	QL (30 EA per 30 days)
<i>zolpidem oral tablet,ext release multiphase</i>	Tier-2	STPA; QL (30 EA per 30 days)
ZOLPIMIST	Tier-4	STPA
NARCOLEPSY		
<i>modafinil</i>	Tier-2	STPA
NUVIGIL ORAL TABLET 150 MG, 250 MG, 50 MG	Tier-4	STPA
XYREM	Tier-5	LA
OPIOID ANTAGONISTS		
<i>buprenorphine-naloxone</i>	Tier-2	PA
<i>naloxone injection syringe 1 mg/ml</i>	Tier-2	
SUBOXONE SUBLINGUAL FILM	Tier-4	PA; QL (90 EA per 30 days)
ZUBSOLV	Tier-4	PA
PSYCHOSES		
ABILIFY INTRAMUSCULAR	Tier-3	
ABILIFY ORAL	Tier-4	STPA
ABILIFY DISCMELT	Tier-4	STPA
ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 300 MG	Tier-3	
<i>chlorpromazine</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
<i>clozapine oral tablet</i>	Tier-2	
FANAPT	Tier-4	
FAZACLO	Tier-3	
<i>fluphenazine decanoate</i>	Tier-2	
<i>fluphenazine hcl</i>	Tier-2	
GEODON INTRAMUSCULAR	Tier-4	
<i>haloperidol</i>	Tier-1	
<i>haloperidol decanoate</i>	Tier-2	
<i>haloperidol lactate</i>	Tier-2	
INVEGA	Tier-4	STPA
INVEGA SUSTENNA	Tier-3	
LATUDA ORAL TABLET 120 MG, 60 MG	Tier-4	QL (30 EA per 30 Days)
LATUDA ORAL TABLET 20 MG, 40 MG	Tier-4	QL (30 EA per 30 days)
LATUDA ORAL TABLET 80 MG	Tier-4	QL (60 EA per 30 Days)
<i>loxapine succinate</i>	Tier-2	
<i>olanzapine intramuscular</i>	Tier-2	
<i>olanzapine oral</i>	Tier-2	STPA
ORAP	Tier-3	
<i>perphenazine</i>	Tier-2	
<i>perphenazine-amitriptyline</i>	Tier-2	
<i>quetiapine oral tablet 100 mg, 200 mg, 300 mg, 400 mg</i>	Tier-2	STPA
<i>quetiapine oral tablet 25 mg, 50 mg</i>	Tier-2	STPA; QL (60 EA per 30 days)
RISPERDAL CONSTA INTRAMUSCULAR SYRINGE 12.5 MG/2 ML, 25 MG/2 ML, 37.5 MG/2 ML	Tier-3	
<i>risperidone oral solution</i>	Tier-2	
<i>risperidone oral tablet</i>	Tier-2	
SAPHRIS (BLACK CHERRY)	Tier-4	
SEROQUEL XR	Tier-3	STPA
<i>thioridazine</i>	Tier-1	
<i>thiothixene</i>	Tier-1	
<i>trifluoperazine</i>	Tier-2	
VERSACLOZ	Tier-4	
<i>ziprasidone hcl</i>	Tier-2	STPA
ZYPREXA INTRAMUSCULAR	Tier-3	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
RESPIRATORY DRUGS		
ASTHMA		
ADVAIR DISKUS	Tier-3	QL (180 EA per 90 days)
ADVAIR HFA	Tier-3	QL (72 GM per 90 days)
<i>albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %)</i>	Tier-2	QL (1080 ML per 90 days)
<i>albuterol sulfate inhalation solution for nebulization 5 mg/ml</i>	Tier-2	QL (180 ML per 90 days)
<i>albuterol sulfate oral</i>	Tier-1	
ALVESCO INHALATION HFA AEROSOL INHALER 160 MCG/ACTUATION	Tier-4	QL (36.6 GM per 90 days)
ALVESCO INHALATION HFA AEROSOL INHALER 80 MCG/ACTUATION	Tier-4	QL (18.3 GM per 90 days)
<i>aminophylline intravenous solution 250 mg/10 ml</i>	Tier-2	
ANORO ELLIPTA	Tier-3	QL (180 EA per 90 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG (30 DOSES), 220 MCG (120 DOSES), 220 MCG (30 DOSES), 220 MCG (60 DOSES)	Tier-3	QL (360 EA per 90 Days)
ATROVENT HFA	Tier-3	QL (77.4 GM per 90 days)
BREO ELLIPTA	Tier-3	QL (180 EA per 90 days)
BROVANA	Tier-4	QL (360 ML per 90 days)
<i>budesonide inhalation</i>	Tier-2	QL (720 ML per 90 days)
COMBIVENT RESPIMAT	Tier-3	QL (24 GM per 90 days)
<i>cromolyn inhalation</i>	Tier-2	QL (720 ML per 90 days)
<i>elixophyllin oral elixir 80 mg/15 ml</i>	Tier-2	
FLOVENT DISKUS	Tier-3	QL (360 EA per 90 days)
FLOVENT HFA INHALATION AEROSOL 110 MCG/ACTUATION, 220 MCG/ACTUATION	Tier-3	QL (72 GM per 90 days)
FLOVENT HFA INHALATION AEROSOL 44 MCG/ACTUATION	Tier-3	QL (63.6 GM per 90 days)
FORADIL AEROLIZER	Tier-4	QL (180 EA per 90 Days)
<i>ipratropium bromide inhalation</i>	Tier-2	QL (900 ML per 90 days)
<i>ipratropium-albuterol</i>	Tier-2	QL (1620 ML per 90 days)
<i>levalbuterol hcl inhalation solution for nebulization 0.31 mg/3 ml, 0.63 mg/3 ml</i>	Tier-2	QL (810 ML per 90 Days)
<i>levalbuterol hcl inhalation solution for nebulization 1.25 mg/0.5 ml</i>	Tier-2	QL (270 EA per 90 days)

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
LUFYLLIN	Tier-4	
<i>metaproterenol oral</i>	Tier-2	
<i>montelukast</i>	Tier-2	
PERFOROMIST	Tier-3	QL (360 ML per 90 Days)
PROAIR HFA	Tier-3	QL (51 GM per 90 days)
PROVENTIL HFA	Tier-4	QL (40.2 GM per 90 days)
PULMICORT INHALATION SUSPENSION FOR NEBULIZATION 1 MG/2 ML	Tier-4	QL (720 ML per 90 days)
PULMICORT FLEXHALER	Tier-4	QL (6 EA per 90 days)
QVAR	Tier-3	QL (52.2 GM per 90 days)
SEREVENT DISKUS	Tier-3	QL (180 EA per 90 days)
SPIRIVA WITH HANDIHALER	Tier-3	QL (90 EA per 90 days)
SYMBICORT	Tier-3	QL (30.6 GM per 90 Days)
<i>terbutaline oral</i>	Tier-2	
<i>theophylline oral solution</i>	Tier-2	
<i>theophylline oral tablet extended release</i>	Tier-2	
<i>theophylline oral tablet extended release 12 hr</i>	Tier-2	
TUDORZA PRESSAIR	Tier-4	QL (3 EA per 90 days)
VENTOLIN HFA	Tier-4	QL (108 GM per 90 days)
XOPENEX HFA	Tier-4	QL (90 GM per 90 days)
<i>zafirlukast</i>	Tier-2	
PULMONARY HYPERTENSION		
<i>epoprostenol (glycine)</i>	Tier-2	PA
ORENITRAM	Tier-4	PA; QL (60 EA per 30 days)
TYVASO	Tier-3	PA
VENTAVIS	Tier-3	PA
RESPIRATORY DRUGS, MISCELLANEOUS		
<i>acetylcysteine solution</i>	Tier-2	
ARALAST NP INTRAVENOUS RECON SOLN 500 MG	Tier-3	
DALIRESP	Tier-4	
GLASSIA	Tier-3	
PROLASTIN-C	Tier-3	
PROLIA	Tier-3	PA
XOLAIR	Tier-3	PA
ZEMAIRA	Tier-3	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
SKIN		
ACNE ROSACEA		
FINACEA	Tier-3	
METROGEL TOPICAL GEL 1 %	Tier-4	
<i>metronidazole topical cream</i>	Tier-2	
<i>metronidazole topical gel</i>	Tier-2	
<i>metronidazole topical lotion</i>	Tier-2	
NORITATE	Tier-4	
ACNE VULGARIS		
<i>adapalene topical cream</i>	Tier-2	PA
<i>adapalene topical gel</i>	Tier-2	PA
<i>amnesteam</i>	Tier-2	
ATRALIN	Tier-4	PA
<i>avita</i>	Tier-2	PA
AZELEX	Tier-4	
<i>claravis</i>	Tier-2	
<i>clindamycin phosphate topical</i>	Tier-2	
<i>clindamycin-benzoyl peroxide topical gel 1-5 %</i>	Tier-2	
DIFFERIN TOPICAL GEL 0.3 %	Tier-4	PA
DIFFERIN TOPICAL LOTION	Tier-4	PA
<i>ery pads</i>	Tier-2	
<i>erythromycin with ethanol topical gel</i>	Tier-2	
<i>erythromycin with ethanol topical solution</i>	Tier-2	
<i>erythromycin-benzoyl peroxide</i>	Tier-2	
FABIOR	Tier-4	PA
<i>neuac</i>	Tier-2	
RETIN-A	Tier-4	PA
RETIN-A MICRO	Tier-4	PA
RETIN-A MICRO PUMP TOPICAL GEL WITH PUMP 0.08 %	Tier-4	PA
TRETIN-X CREAM KIT	Tier-4	PA
<i>tretinoin topical</i>	Tier-2	PA
BACTERIAL INFECTIONS, TOPICAL		
ALTABAX	Tier-4	
CORTISPORIN TOPICAL	Tier-4	
<i>gentamicin topical</i>	Tier-1	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
<i>mupirocin</i>	Tier-2	
<i>mupirocin calcium</i>	Tier-2	
<i>silver sulfadiazine</i>	Tier-2	
<i>ssd</i>	Tier-2	
CORTICOSTEROIDS, TOPICAL		
<i>ala-cort topical cream</i>	Tier-1	
ALA-SCALP	Tier-4	
<i>alclometasone</i>	Tier-2	
<i>amcinonide</i>	Tier-2	
<i>betamethasone dipropionate</i>	Tier-2	
<i>betamethasone valerate</i>	Tier-2	
<i>betamethasone, augmented</i>	Tier-2	
CAPEX	Tier-4	
<i>clobetasol topical foam</i>	Tier-2	
<i>clobetasol topical gel</i>	Tier-2	
<i>clobetasol topical lotion</i>	Tier-2	
<i>clobetasol topical ointment</i>	Tier-2	
<i>clobetasol topical shampoo</i>	Tier-2	
<i>clobetasol topical solution</i>	Tier-2	
<i>clobetasol-emollient topical cream</i>	Tier-2	
CLOBEX TOPICAL SPRAY, NON-AEROSOL	Tier-4	
<i>clodan</i>	Tier-2	
CLODERM	Tier-4	
CORDRAN TOPICAL LOTION	Tier-4	
CORDRAN TAPE LARGE ROLL	Tier-4	
<i>desonide</i>	Tier-2	
<i>desoximetasone</i>	Tier-2	
<i>diflorasone</i>	Tier-2	
<i>fluocinolone</i>	Tier-1	
<i>fluocinonide topical cream 0.1 %</i>	Tier-1	
<i>fluocinonide topical gel</i>	Tier-1	
<i>fluocinonide topical ointment</i>	Tier-1	
<i>fluocinonide topical solution</i>	Tier-1	
<i>fluocinonide-e</i>	Tier-1	
<i>fluticasone topical</i>	Tier-2	
<i>halobetasol propionate</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
HALOG	Tier-4	
<i>hydrocortisone topical cream 1 %, 2.5 %</i>	Tier-1	
<i>hydrocortisone topical lotion 2.5 %</i>	Tier-1	
<i>hydrocortisone topical ointment 1 %, 2.5 %</i>	Tier-1	
<i>hydrocortisone butyr-emollient</i>	Tier-1	
<i>hydrocortisone butyrate</i>	Tier-1	
<i>hydrocortisone valerate</i>	Tier-1	
KENALOG TOPICAL	Tier-4	
<i>lokara</i>	Tier-2	
<i>mometasone</i>	Tier-2	
NEO-SYNALAR	Tier-4	
PANDEL	Tier-4	
<i>prednicarbate</i>	Tier-2	
<i>triamcinolone acetonide topical cream</i>	Tier-2	
<i>triamcinolone acetonide topical lotion</i>	Tier-2	
<i>triamcinolone acetonide topical ointment 0.025 %, 0.1 %, 0.5 %</i>	Tier-2	
<i>triderm topical cream</i>	Tier-2	
<i>u-cort</i>	Tier-1	
VANOS	Tier-4	
FUNGAL INFECTIONS, TOPICAL		
<i>ciclopirox</i>	Tier-2	
<i>clotrimazole topical</i>	Tier-2	
<i>clotrimazole-betamethasone</i>	Tier-2	
<i>econazole topical</i>	Tier-2	
ERTACZO	Tier-4	
EXELDERM	Tier-4	
<i>ketoconazole topical cream</i>	Tier-2	
<i>ketoconazole topical shampoo</i>	Tier-2	
MENTAX	Tier-4	
<i>nyamyc</i>	Tier-2	
<i>nystatin oral suspension</i>	Tier-2	
<i>nystatin topical cream</i>	Tier-1	
<i>nystatin topical ointment</i>	Tier-2	
<i>nystatin topical powder</i>	Tier-2	
<i>nystatin-triamcinolone</i>	Tier-1	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
<i>nystop</i>	Tier-2	
OXISTAT	Tier-3	
<i>pedi-dri</i>	Tier-2	
PSORIASIS AND SEBORRHEA		
<i>acitretin</i>	Tier-2	
<i>calcipotriene</i>	Tier-2	
<i>calcitriol topical</i>	Tier-2	
DOVONEX	Tier-3	
<i>methoxsalen rapid</i>	Tier-2	
OXSORALEN	Tier-3	
OXSORALEN ULTRA	Tier-3	
SORIATANE ORAL CAPSULE 10 MG, 17.5 MG, 25 MG	Tier-3	
STELARA SUBCUTANEOUS SYRINGE	Tier-3	PA
TAZORAC	Tier-3	PA
SCABIES AND PEDICULOSIS		
EURAX	Tier-3	
<i>lindane</i>	Tier-2	
<i>malathion</i>	Tier-2	
<i>permethrin topical cream</i>	Tier-2	
SKLICE	Tier-4	
ULESFIA	Tier-4	
TOPICAL, MISCELLANEOUS		
<i>ammonium lactate topical</i>	Tier-2	
ANUSOL-HC RECTAL CREAM	Tier-4	
<i>calcipotriene-betamethasone</i>	Tier-2	
CARAC	Tier-3	
CORTIFOAM	Tier-4	
ELIDEL	Tier-4	STPA
FLUOROPLEX	Tier-3	
<i>fluorouracil intravenous solution 2.5 gram/50 ml</i>	Tier-2	
<i>fluorouracil topical cream 5 %</i>	Tier-2	
<i>fluorouracil topical solution</i>	Tier-2	
<i>laclotion</i>	Tier-2	
<i>lidocaine topical adhesive patch,medicated</i>	Tier-3	PA; QL (90 EA per 30 Days)
<i>lidocaine topical ointment</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
<i>lidocaine hcl mucous membrane</i>	Tier-2	
<i>lidocaine-prilocaine topical cream</i>	Tier-2	
LIDODERM	Tier-3	PA; QL (90 EA per 30 days)
<i>mafenide acetate</i>	Tier-2	
PANRETIN	Tier-5	
PICATO	Tier-4	
<i>proctocream-hc</i>	Tier-2	
<i>proctosol hc</i>	Tier-2	
PROTOPIC	Tier-4	STPA
<i>prudoxin</i>	Tier-2	
REGRANEX	Tier-3	
SANTYL	Tier-3	
<i>selenium sulfide topical suspension 2.5 %</i>	Tier-2	
<i>sodium chloride irrigation</i>	Tier-2	
SOLARAZE	Tier-3	
<i>sulfacetamide sodium (acne)</i>	Tier-2	
SULFAMYLON	Tier-4	
SYNERA	Tier-3	
TARGRETIN TOPICAL	Tier-5	
<i>water for irrigation, sterile</i>	Tier-2	
ZONALON	Tier-4	
VIRAL INFECTIONS, TOPICAL		
<i>acyclovir topical</i>	Tier-2	
CONDYLOX TOPICAL GEL	Tier-4	
DENAVIR	Tier-4	
<i>imiquimod</i>	Tier-2	
<i>podofilox</i>	Tier-2	
ZOVIRAX TOPICAL CREAM	Tier-3	
WOMENS HEALTH		
CONTRACEPTIVES		
<i>amethia</i>	Tier-2	
<i>amethyst</i>	Tier-2	
<i>apri</i>	Tier-2	
<i>aranelle (28)</i>	Tier-2	
<i>aubra</i>	Tier-2	
<i>aviane</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
<i>balziva (28)</i>	Tier-2	
BEYAZ	Tier-4	
<i>briellyn</i>	Tier-2	
<i>camila</i>	Tier-2	
<i>delyla (28)</i>	Tier-2	
<i>drospirenone-ethinyl estradiol</i>	Tier-2	
ELLA	Tier-4	QL (1 EA per 1 day)
<i>emoquette</i>	Tier-2	
<i>errin</i>	Tier-2	
<i>estradiol-norethindrone acet</i>	Tier-2	
<i>falmina (28)</i>	Tier-2	
GENERESS FE	Tier-4	
<i>gianvi (28)</i>	Tier-2	
<i>gildagia</i>	Tier-2	
<i>gildess oral tablet 1.5-30 mg-mcg</i>	Tier-2	
<i>introvale</i>	Tier-2	
<i>jinteli</i>	Tier-2	
<i>junel 1.5/30 (21)</i>	Tier-2	
<i>junel 1/20 (21)</i>	Tier-2	
<i>junel fe 1.5/30 (28)</i>	Tier-2	
<i>junel fe 1/20 (28)</i>	Tier-2	
<i>kariva (28)</i>	Tier-2	
<i>kelnor 1/35 (28)</i>	Tier-2	
<i>larin 1.5/30 (21)</i>	Tier-2	
<i>leena 28</i>	Tier-2	
<i>lessina</i>	Tier-2	
<i>levonest (28)</i>	Tier-2	
<i>levonorgestrel-ethinyl estrad oral tablets,dose pack,3 month</i>	Tier-2	
<i>levora-28</i>	Tier-2	
LO LOESTRIN FE	Tier-4	
<i>low-ogestrel (28)</i>	Tier-2	
<i>marlissa</i>	Tier-2	
MINASTRIN 24 FE	Tier-3	
<i>necon 0.5/35 (28)</i>	Tier-2	
<i>necon 1/35 (28)</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
NECON 10/11 (28)	Tier-3	
<i>necon 7/7/7 (28)</i>	Tier-2	
<i>nikki (28)</i>	Tier-2	
<i>nora-be</i>	Tier-2	
<i>norlyroc</i>	Tier-2	
<i>nortrel 0.5/35 (28)</i>	Tier-2	
<i>nortrel 1/35 (21)</i>	Tier-2	
<i>nortrel 1/35 (28)</i>	Tier-2	
<i>nortrel 7/7/7 (28)</i>	Tier-2	
NUVARING	Tier-3	
<i>orsythia</i>	Tier-2	
ORTHO EVRA	Tier-4	
ORTHO TRI-CYCLEN (28)	Tier-4	
OVCON-50 (28)	Tier-4	
<i>portia</i>	Tier-2	
<i>quasense</i>	Tier-2	
SAFYRAL	Tier-4	
<i>tri-previfem (28)</i>	Tier-2	
<i>tri-sprintec (28)</i>	Tier-2	
<i>trinessa (28)</i>	Tier-2	
<i>trivora (28)</i>	Tier-2	
<i>velivet triphasic regimen (28)</i>	Tier-2	
<i>vyfemla (28)</i>	Tier-2	
ZENCHENT (28)	Tier-4	
ZENCHENT FE	Tier-4	
<i>zeosa</i>	Tier-2	
<i>zovia 1/35e (28)</i>	Tier-2	
<i>zovia 1/50e (28)</i>	Tier-2	
MENOPAUSAL SYMPTOMS/OSTEOPOROSIS		
ACTONEL	Tier-4	STPA
<i>alendronate</i>	Tier-2	
ALORA	Tier-4	
ANGELIQ ORAL TABLET 0.5-1 MG	Tier-4	
<i>calcitonin (salmon)</i>	Tier-2	
CENESTIN	Tier-4	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
CLIMARA PRO	Tier-4	
COMBIPATCH	Tier-4	
CRINONE VAGINAL GEL 8 %	Tier-3	
DELESTROGEN	Tier-4	
DEPO-ESTRADIOL	Tier-3	
DEPO-PROVERA INTRAMUSCULAR SOLUTION	Tier-3	
DEPO-PROVERA INTRAMUSCULAR SUSPENSION	Tier-3	
DEPO-SUBQ PROVERA 104	Tier-3	
DIVIGEL TRANSDERMAL GEL IN PACKET 1 (0.1) MG (%)	Tier-4	
ELESTRIN	Tier-4	
ENJUVIA	Tier-4	
ESTRACE VAGINAL	Tier-3	
<i>estradiol oral</i>	Tier-1	
<i>estradiol transdermal</i>	Tier-3	
<i>estradiol valerate</i>	Tier-2	
ESTRING	Tier-3	
<i>estropipate</i>	Tier-2	
EVAMIST	Tier-4	
EVISTA	Tier-3	
FEMHRT 1/5	Tier-4	
FEMHRT LOW DOSE	Tier-4	
FEMRING	Tier-3	
FORTEO	Tier-5	PA
<i>ibandronate intravenous solution</i>	Tier-2	
<i>ibandronate oral</i>	Tier-3	STPA
<i>medroxyprogesterone oral</i>	Tier-1	
MENEST	Tier-4	
MENOSTAR	Tier-4	
<i>methylgonovine oral</i>	Tier-2	
MIACALCIN INJECTION	Tier-3	
MINIVELLE	Tier-4	
<i>norethindrone acetate</i>	Tier-2	
PREMARIN	Tier-4	
PREMPHASE	Tier-4	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

Drug Name	Drug Tier	Requirements/Limits
PREMPRO	Tier-4	
<i>progesterone micronized</i>	Tier-2	
<i>raloxifene</i>	Tier-3	
RECLAST	Tier-3	PA
<i>risedronate</i>	Tier-3	
VAGIFEM	Tier-3	
VIVELLE-DOT	Tier-3	
XGEVA	Tier-3	PA
<i>xulane</i>	Tier-2	
<i>zoledronic acid intravenous solution</i>	Tier-2	PA
<i>zoledronic acid-mannitol-water intravenous solution</i>	Tier-2	PA
ZOMETA	Tier-3	PA
PRENATAL VITAMINS		
<i>prenatal vitamin oral tablet</i>	Tier-2	
VAGINAL INFECTIONS		
CLEOCIN VAGINAL SUPPOSITORY	Tier-4	
<i>clindamycin phosphate vaginal</i>	Tier-2	
<i>fluconazole oral tablet 150 mg</i>	Tier-1	
GYNAZOLE-1 VAGINAL CREAM	Tier-4	
<i>metronidazole vaginal</i>	Tier-2	
<i>miconazole-3 vaginal suppository</i>	Tier-2	
<i>terconazole</i>	Tier-2	
<i>vandazole</i>	Tier-2	
<i>zazole</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

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.....	27	<i>alcohol swabs</i>	37
<i>acetazolamide sodium</i>		AMINOSYN M 3.5 %	
.....	31	ALDURAZYME	37
<i>acetic acid</i>	24	AMINOSYN-HBC 7%	
<i>acetylcysteine</i>		<i>alendronate</i>	37
.....	62	<i>alfuzosin</i>	AMINOSYN-PF 10 %	
<i>acitretin</i>	66	ALIMTA	37
ACTEMRA	52	ALINIA	AMINOSYN-PF 7 %	
ACTHIB (PF)		ALKERAN	(SULFITE-FREE)	
.....	40	<i>allopurinol</i>	37
ACTIMMUNE		ALOCRIAL	<i>amiodarone</i>	17
.....	40	ALOMIDE	AMITIZA	31
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.....	23	ALPHAGAN P	56
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.....	31	<i>amlodipine-atorvastatin</i>	
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For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

<i>amlodipine-benazepril</i>	18	ARGATROBAN IN 0.9 % SOD	31	<i>aztreonam</i>	32
<i>ammonium chloride</i>	36	CHLOR	11	<i>bacitracin</i>	26
<i>ammonium lactate</i>	66	ARRANON	52	<i>bacitracin-polymyxin b</i>	26
<i>amnesteem</i>	63	ARTHROTEC 50	52	<i>baclofen</i>	52
<i>amoxapine</i>	57	ARTHROTEC 75	52	BACTROBAN NASAL	25
<i>amoxicil-clarithromy-lansopraz</i>	30	ARZERRA	11	<i>balsalazide</i>	31
<i>amoxicillin</i>	7	ASACOL HD	31	<i>balziva (28)</i>	68
<i>amoxicillin-pot clavulanate</i>	7	ASMANEX TWISTHALER	61	BANZEL	50
<i>amphetamine salt combo</i>	56	ASTAGRAF XL	43	BARACLUDGE	5
<i>amphotericin b</i>	31	ASTEPRO	25	<i>bcg vaccine, live (pf)</i>	41
<i>ampicillin</i>	7	<i>atenolol</i>	19	BELEODAQ	11
<i>ampicillin sodium</i>	31	<i>atenolol-chlorthalidone</i>	18	<i>benazepril</i>	16
<i>ampicillin-sulbactam</i>	31	ATGAM	31	<i>benazepril-hydrochlorothiazide</i>	18
AMPYRA	46	<i>atorvastatin</i>	21	BENICAR	17
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<i>anagrelide</i>	11	<i>atovaquone-proguanil</i>	4	BENLYSTA	43
<i>anastrozole</i>	14	ATRALIN	63	<i>benztropine</i>	32
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ANDROGEL	39	<i>atropine</i>	31, 32	<i>betamethasone dipropionate</i>	64
ANDROXY	39	ATROVENT HFA	61	<i>betamethasone valerate</i>	64
ANGELIQ	69	AUBAGIO	46	<i>betamethasone, augmented</i>	64
ANORO ELLIPTA	61	<i>aubra</i>	67	BETASERON	46
ANUSOL-HC	66	AUVI-Q	44	<i>betaxolol</i>	19
ANZEMET	28	AVASTIN	11	<i>bethanechol chloride</i>	48
APLENZIN	57	AVELOX IN NACL (ISO-OSMOTIC)	32	BETHKIS	44
APOKYN	49	<i>aviane</i>	67	BETIMOL	27
<i>apraclonidine</i>	27	<i>avita</i>	63	BETOPTIC S	27
<i>apri</i>	67	AVODART	47	BEYAZ	68
APRISO	31	AVONEX	46	<i>bicalutamide</i>	14
APTIOM	50	<i>azacitidine</i>	11	BICILLIN C-R	7
APTIVUS	5	AZACTAM	32	BICILLIN L-A	7
ARALAST NP	62	AZACTAM IN DEXTROSE (ISO-OSM)	32	BICNU	11
<i>aranelle (28)</i>	67	AZASAN	52	BIDIL	22
ARANESP (IN POLYSORBATE)	10	AZASITE	26	BILTRICIDE	4
ARCALYST	44	<i>azathioprine</i>	52	<i>bisoprolol fumarate</i>	19
ARGATROBAN	31	<i>azelastine</i>	25	<i>bisoprolol-hydrochlorothiazide</i>	18
		AZELEX	63	BIVIGAM	41
		AZILECT	49		
		<i>azithromycin</i>	8		
		AZOPT	27		
		AZOR	18		

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

<i>bleomycin</i>	11	CANASA	31	<i>ceftazidime in d5w</i>	
BLEPHAMIDE		CANCIDAS	32	.....	32
.....	26	<i>candesartan</i>	17	<i>ceftriaxone</i>	32
BLEPHAMIDE S.O.P.		<i>candesartan-hydrochlorothiazid</i>		<i>cefuroxime axetil</i>	
.....	26	18	8
BONIVA	32	CANTIL	29	<i>cefuroxime sodium</i>	
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.....	61	<i>captopril</i>	16	CENESTIN	69
<i>briellyn</i>	68	<i>captopril-hydrochlorothiazide</i>		<i>cephalexin</i>	8
BRILINTA	10	18	CEREZYME	44
<i>brimonidine</i>	27	CARAC	66	CERVARIX VACCINE (PF)	
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.....	57	<i>carbamazepine</i>		CESAMET	28
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.....	49	<i>carbidopa-levodopa</i>		CHANTIX STARTING MONTH	
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<i>budeprion sr</i>	57	49	CHEMET	44
<i>budesonide</i>	25	<i>carboplatin</i>	11	<i>chloramphenicol sod succinate</i>	
<i>bumetanide</i>	20	CARDENE IV IN SODIUM		.....	32
BUPHENYL	29	CHLORIDE	19	<i>chlorhexidine gluconate</i>	
<i>buprenorphine hcl</i>		CARDURA XL .....		.....	25
.....	32	.....	16	<i>chloroquine phosphate</i>	
<i>buprenorphine-naloxone</i>		CARIMUNE NF		<i>chlorothiazide</i>	
.....	59	NANOFILTERED		.....	20
<i>buproban</i>	47	.....	41	<i>chlorpromazine</i>	
<i>bupropion hcl</i>		<i>carteolol</i>	27	.....	59
.....	57	<i>cartia xt</i>	19	<i>chlorpropamide</i>	
<i>buspirone</i>	56	<i>carvedilol</i>	19	.....	23
BUSULFEX	11	CAYSTON	44	<i>chlorthalidone</i>	
<i>butalbital-acetaminop-caf-cod</i>		CEDAX	7	.....	20
.....	49	CEENU	14	<i>cholestyramine light</i>	
<i>butorphanol tartrate</i>		<i>cefaclor</i>	7	.....	21
.....	32	<i>cefadroxil</i>	7	CIALIS	47
BUTRANS	54	<i>cefazolin</i>	32	<i>ciclopirox</i>	65
BYDUREON	23	<i>cefazolin in dextrose (iso-os)</i>		<i>cidofovir</i>	32, 33
BYETTA	23	<i>cefdinir</i>	7	<i>cilostazol</i>	11
<i>cabergoline</i>	49	<i>cefepime</i>	32	<i>cimetidine</i>	
<i>calcipotriene</i>	66	<i>cefotaxime</i>	32	<i>cimetidine hcl</i>	
<i>calcipotriene-betamethasone</i>		<i>cefotetan</i>	32	.....	30
.....	66	<i>cefoxitin</i>	32	CIMZIA	52
<i>calcitonin (salmon)</i>		<i>cefoxitin in dextrose, iso-osm</i>		CIMZIA POWDER FOR	
.....	69	.....	32	RECONST	52
<i>calcitriol</i>	32	<i>cefpodoxime</i>	8	CINRYZE	45
<i>calcium acetate</i>		<i>cefprozil</i>	8	CIPRO	9
.....	46	<i>ceftazidime</i>	32	CIPRO HC	24
<i>camila</i>	68		CIPRO XR	9
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For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

<i>ciprofloxacin</i>	9	CLINIMIX E 5%/D20W SULFIT	64	CORDRAN	64
<i>ciprofloxacin (mixture)</i>	9	FREE	38	CORDRAN TAPE LARGE ROLL	64
<i>ciprofloxacin in 5 % dextrose</i>	33	CLINIMIX E 5%/D25W SULFIT	64	COREG CR	19
<i>cisplatin</i>	11	FREE	38	CORTIFOAM	66
<i>citalopram</i>	57	CLINISOL SF 15 %	64	<i>cortisone</i>	38
<i>cladribine</i>	11	<i>clobetasol</i>	64	CORTISPORIN	63
<i>claravis</i>	63	<i>clobetasol-emollient</i>	64	CORTISPORIN-TC	24
<i>clarithromycin</i>	8	.....	64	COSMEGEN	12
CLEOCIN	33	CLOBEX	64	COSOPT	28
CLEOCIN IN 5 % DEXTROSE	33	<i>clodan</i>	64	COUMADIN	10
CLIMARA PRO	70	CLODERM	64	CREON	29
<i>clindamycin hcl</i>	8	CLOLAR	12	CRINONE	70
<i>clindamycin pediatric</i>	8	<i>clomipramine</i>	57	CRIXIVAN	5
<i>clindamycin phosphate</i>	33	<i>clonazepam</i>	50	<i>cromolyn</i>	26
<i>clindamycin-benzoyl peroxide</i>	63	<i>clonidine</i>	20	CUBICIN	33
CLINIMIX 5%/D15W SULFITE	37	<i>clonidine hcl</i>	20	<i>cyclobenzaprine</i>	52
FREE	37	<i>clodogrel</i>	10	CYCLOPHOSPHAMIDE	14
CLINIMIX 5%/D25W	37	<i>clorazepate dipotassium</i>	56	<i>cyclophosphamide</i>	14
SULFITE-FREE	37	.....	18	.....	49
CLINIMIX 2.75%/D5W SULFIT	37	<i>clorpres</i>	18	CYCLOSET	33
FREE	37	<i>clotrimazole</i>	3	<i>cyclosporine</i>	43
CLINIMIX 4.25%/D10W SULF	38	<i>clotrimazole-betamethasone</i>	65	<i>cyclosporine modified</i>	43
FREE	38	.....	60	CYKLOKAPRON	33
CLINIMIX 4.25%/D5W SULFIT	38	<i>clozapine</i>	60	CYMBALTA	57
FREE	38	COARTEM	4	<i>cyproheptadine</i>	25
CLINIMIX 4.25%-D20W	37	<i>codeine sulfate</i>	54	CYSTADANE	44
SULF-FREE	37	<i>colchicine-probenecid</i>	53	CYSTAGON	29
CLINIMIX 4.25%-D25W	37	COLCRYS	53	<i>cytarabine</i>	12
SULF-FREE	37	<i>colestipol</i>	21	<i>cytarabine (pf)</i>	12
CLINIMIX	38	<i>colistin (colistimethate na)</i>	33	.....	12
5%-D20W(SULFITE-FREE)	38	.....	31	CYTOVENE	12
CLINIMIX E 2.75%/D10W SUL	38	<i>colocort</i>	31	<i>d10 % & 0.45 % sodium chloride</i>	36
FREE	38	COLY-MYCIN S	24	<i>d2.5 %-0.45 % sodium chloride</i>	36
CLINIMIX E 2.75%/D5W SULF	38	.....	28	<i>d5 % and 0.9 % sodium chloride</i>	36
FREE	38	COMBIGAN	28	<i>d5 %-0.45 % sodium chloride</i>	36
CLINIMIX E 4.25%/D25W SUL	38	COMBIPATCH	70	<i>dacarbazine</i>	12
FREE	38	COMBIVENT RESPIMAT	61	DACOGEN	12
CLINIMIX E 4.25%/D5W SULF	38	.....	14	DALIRESP	62
FREE	38	COMETRIQ	5		
CLINIMIX E 5%/D15W SULFIT	38	COMPLERA	28		
FREE	38	<i>compro</i>	41		
CLINIMIX E 5%/D15W SULFIT	38	COMVAX (PF)	67		
FREE	38	CONDYLOX	29		
		<i>constulose</i>	46		
		COPAXONE	5		
		COPEGUS			

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

<i>danazol</i>	39	<i>dexmethylphenidate</i>	56	<i>disopyramide phosphate</i>	17
<i>dantrolene</i>	52	<i>dexpak 13 day</i>	38	<i>disulfiram</i>	56
<i>dapsone</i>	4	<i>dextrazoxane hcl</i>	12	<i>divalproex</i>	50
DAPTACEL (DTAP PEDIATRIC) (PF)	41	<i>dextroamphetamine</i>	56	DIVIGEL	70
DARAPRIM	4	<i>dextroamphetamine-amphetamine</i>	56	DOCEFREZ	12
<i>daunorubicin</i>	12	<i>dextrose 10 % and 0.2 % nacl</i>	36	<i>docetaxel</i>	12
DAYTRANA	56	<i>dextrose 10 % in water (d10w)</i>	36	<i>donepezil</i>	48
DECAVAC (PF)	41	<i>dextrose 5 % in water (d5w)</i>	36	DORIBAX	33
<i>decitabine</i>	12	<i>dextrose 5 %-lactated ringers</i>	36	<i>dorzolamide</i>	28
DELESTROGEN	70	<i>dextrose 5%-0.2 % sod chloride</i>	36	<i>dorzolamide-timolol</i>	28
<i>delyla (28)</i>	68	<i>dextrose 5%-0.3 % sod.chloride</i>	36	DOVONEX	66
DELZICOL	31	<i>diazepam</i>	50	<i>doxazosin</i>	16
<i>demeclocycline</i>	9	<i>diazepam intensol</i>	50	<i>doxepin</i>	58
DENAVIR	67	<i>diclofenac potassium</i>	52	<i>doxercalciferol</i>	46
DEPEN TITRATABS	48	<i>diclofenac sodium</i>	27	<i>doxorubicin</i>	12
DEPO-ESTRADIOL	70	<i>diclofenac-misoprostol</i>	52	<i>doxycycline hyclate</i>	9
DEPO-MEDROL	38	<i>dicloxacillin</i>	8	<i>doxycycline monohydrate</i>	9
DEPO-PROVERA	70	<i>dicyclomine</i>	29	<i>dronabinol</i>	28
DEPO-SUBQ PROVERA 104	70	<i>didanosine</i>	5	<i>drosiprenone-ethinyl estradiol</i>	68
DEPO-TESTOSTERONE	39	DIFFERIN	63	DROXIA	14
<i>desipramine</i>	57	DIFICID	8	<i>duloxetine</i>	58
<i>desloratadine</i>	25	<i>diflorasone</i>	64	<i>duramorph (pf)</i>	33
<i>desmopressin</i>	48	<i>diflunisal</i>	54	DUTOPROL	18
<i>desonide</i>	64	<i>digoxin</i>	17	<i>e.e.s. 400</i>	8
<i>desoximetasone</i>	64	<i>dihydroergotamine</i>	49	E.E.S. GRANULES	8
DESOXYN	56	DILANTIN	50	<i>econazole</i>	65
DESVENLAFAXINE	58	DILANTIN INFATABS	50	EDURANT	5
DETROL LA	48	DILAUDID	54	EFFIENT	10
<i>dexamethasone</i>	38	<i>dilt-cd</i>	19	EGRIFTA	45
<i>dexamethasone intensol</i>	38	<i>diltiazem hcl</i>	19	ELAPRASE	46
<i>dexamethasone sodium phosphate</i>	27	<i>dilt-xr</i>	19	ELELYSO	44
<i>dexedrine</i>	56	DIOVAN	17	ELESTRIN	70
DEXEDRINE SPANSULE	56	DIPENTUM	31	ELIDEL	66
		<i>dipyridamole</i>	10	ELIGARD	38
				ELIQUIS	10
				ELITEK	12
				<i>elixophyllin</i>	61
				ELLA	68
				ELLENCE	12
				ELMIRON	48
				ELSPAR	12
				EMADINE	26
				EMCYT	14
				EMEND	28

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

<i>emoquette</i>	68	ERYTHROCIN	14	FARESTON	14
EMSAM	58	.....	33	FARXIGA	23
EMTRIVA	5	<i>erythrocin (as stearate)</i>	8	FASLODEX	12
ENABLEX	48	<i>erythromycin</i>	8	FAZACLO	60
<i>enalapril maleate</i>	16	<i>erythromycin ethylsuccinate</i>	8	<i>felbamate</i>	50
.....	18	<i>erythromycin with ethanol</i>	63	<i>felodipine</i>	19
ENBREL	52	<i>erythromycin-benzoyl peroxide</i>	63	FEMHRT 1/5	70
<i>endocet</i>	54	.....	58	FEMHRT LOW DOSE	70
<i>endodan</i>	54	<i>escitalopram oxalate</i>	58	FEMRING	70
ENGERIX-B (PF)	41	.....	33	<i>fenofibrate</i>	21
ENGERIX-B PEDIATRIC (PF)	41	<i>esomeprazole sodium</i>	33	<i>fenofibrate micronized</i>	21
.....	41	.....	59	<i>fenofibrate nanocrystallized</i>	21
ENJUVIA	70	<i>estazolam</i>	59	<i>fenofibric acid (choline)</i>	21
<i>enoxaparin</i>	11	ESTRACE	70	.....	21
<i>entacapone</i>	49	<i>estradiol</i>	70	<i>fenoprofen</i>	52
ENTOCORT EC	31	<i>estradiol valerate</i>	70	<i>fentanyl</i>	54
.....	29	<i>estradiol-norethindrone acet</i>	68	<i>fentanyl citrate</i>	54
EPANED	16	.....	68	FETZIMA	58
<i>epinastine</i>	26	ESTRING	70	FINACEA	63
<i>epinephrine</i>	44	<i>estropipate</i>	70	<i>finasteride</i>	47
EPIPEN 2-PAK	44	<i>eszopiclone</i>	59	FIRAZYR	45
.....	44	<i>ethambutol</i>	8	FIRMAGON	38
EPIPEN JR 2-PAK	44	<i>ethosuximide</i>	50	FLAREX	27
.....	12	<i>etidronate disodium</i>	46	<i>flavoxate</i>	48
<i>epirubicin</i>	12	.....	54	<i>flecainide</i>	17
<i>epitol</i>	50	<i>etodolac</i>	54	FLOLAN	47
EPIVIR	5	ETOPOPHOS	12	FLOVENT DISKUS	61
EPIVIR HBV	5	.....	12	FLOVENT HFA	61
<i>eplerenone</i>	22	<i>etoposide</i>	12	.....	61
EPOGEN	10	EURAX	66	FLUARIX 2011-2012 (PF)	41
<i>epoprostenol (glycine)</i>	62	EVAMIST	70	.....	41
.....	17	EVISTA	70	<i>fluconazole</i>	3
<i>eprosartan</i>	17	EXELDERM	65	<i>fluconazole in dextrose(iso-o)</i>	33
EPZICOM	5	EXELON	48	.....	33
EQUETRO	57	<i>exemestane</i>	14	<i>flucytosine</i>	3
ERAXIS(WATER DILUENT)	33	EXFORGE	18	<i>fludarabine</i>	12
.....	12	EXFORGE HCT	18	<i>fludrocortisone</i>	39
ERBITUX	12	.....	44	FLULAVAL 2011-2012	41
<i>ergoloid</i>	48	EXJADE	44	.....	41
ERIVEDGE	14	EXTAVIA	46	<i>flunisolide</i>	25
<i>errin</i>	68	FABIOR	63	<i>fluocinolone</i>	64
ERTACZO	65	FABRAZYME	44	<i>fluocinolone acetonide oil</i>	24
ERWINAZE	12	.....	9	.....	64
<i>ery pads</i>	63	FACTIVE	9	<i>fluocinonide</i>	64
<i>eryped 200</i>	8	<i>falmina (28)</i>	68	<i>fluocinonide-e</i>	64
<i>eryped 400</i>	8	<i>famciclovir</i>	5	.....	64
ERY-TAB	8	<i>famotidine</i>	30	FANAPT	60
.....	8	FANAPT	60	.....	64

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

<i>fluorometholone</i>	27	FUZEON	5	GLUCAGEN HYPOKIT	22
FLUOROPLEX	66	FYCOMPA	50	GLUCAGON EMERGENCY KIT (HUMAN)	22
<i>fluorouracil</i>	66	<i>gabapentin</i>	50	<i>glyburide</i>	24
<i>fluoxetine</i>	58	GABITRIL	51	<i>glyburide micronized</i>	24
<i>fluphenazine decanoate</i>	60	<i>galantamine</i>	48	<i>glyburide-metformin</i>	24
<i>fluphenazine hcl</i>	60	GAMASTAN S/D	41	<i>glycopyrrolate</i>	29
<i>flurazepam</i>	59	GAMMAGARD LIQUID	41	<i>granisetron (pf)</i>	33
<i>flurbiprofen</i>	52	GAMMAPLEX	41	<i>granisetron hcl</i>	28
<i>flurbiprofen sodium</i>	27	GAMUNEX-C	41	GRANIX	10
<i>flutamide</i>	14	GARAMYCIN	26	GRASTEK	41
<i>fluticasone</i>	25	GARDASIL (PF)	41	<i>griseofulvin microsize</i>	3
<i>fluvastatin</i>	21	<i>gatifloxacin</i>	26	<i>griseofulvin ultramicrosize</i>	3
FLUVIRIN 2011-2012	41	GATTEX ONE-VIAL	29	GRIS-PEG (ULTRAMICROSIZED)	3
FLUVIRIN 2011-2012 (PF)	41	<i>gauze bandage</i>	22	<i>guanfacine</i>	20
<i>fluvoxamine</i>	58	GELNIQUE	48	<i>guanidine</i>	46
FLUZONE 2011-2012	41	<i>gemcitabine</i>	12	GYNAZOLE-1	71
FLUZONE 2011-2012 (PF)	41	<i>gemfibrozil</i>	21	HALAVEN	12
FLUZONE HIGH-DOSE 2011-12 (PF)	41	GENERESS FE	68	HALFLYTELY-BISACODYL W-FLAV PK	29
FLUZONE INTRADERM 2011-12 (PF)	41	<i>generlac</i>	29	<i>halobetasol propionate</i>	64
FML FORTE	27	<i>gengraf</i>	43	HALOG	65
FML S.O.P.	27	GENOTROPIN	45	<i>haloperidol</i>	60
FOCALIN XR	56	GENOTROPIN MINIQUICK	45	<i>haloperidol decanoate</i>	60
<i>fondaparinux</i>	11	<i>gentak</i>	26	<i>haloperidol lactate</i>	60
FORADIL AEROLIZER	61	<i>gentamicin</i>	26	HAVRIX (PF)	41
FORTAZ	33	<i>gentamicin in nacl (iso-osm)</i>	33	HECTOROL	33
FORTAZ IN DEXTROSE 5 %	33	<i>gentamicin sulfate (pf)</i>	33	<i>heparin (porcine)</i>	34
FORTEO	70	GEODON	60	<i>heparin (porcine) in 5 % dex</i>	34
FOSAMAX	41	<i>gianvi (28)</i>	68	<i>heparin (porcine) in nacl (pf)</i>	34
<i>foscarnet</i>	33	<i>gildagia</i>	68	<i>heparin (porcine) in 0.45% nacl</i>	34
<i>fosinopril</i>	16	<i>gildess</i>	68	HEPATAMINE 8%	38
<i>fosinopril-hydrochlorothiazide</i>	18	GILENYA	46	HEPSERA	5
FOSRENOL	47	GILOTRIF	14		
FRAGMIN	11	GLASSIA	62		
FULYZAQ	29	GLEEVEC	14		
<i>furosemide</i>	20	<i>glimepiride</i>	24		
FUSILEV	16	<i>glipizide</i>	24		
		<i>glipizide-metformin</i>	24		

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HERCEPTIN	12	<i>hydrocortisone-acetic acid</i>	24, 25	INTRALIPID	38
HETLIOZ	59	<i>hydromorphone</i>	55	INTRON A	5
HEXALEN	14	<i>hydromorphone (pf)</i>	34	<i>introvale</i>	68
HIBERIX (PF)	42	<i>hydroxychloroquine</i>	4	INTUNIV ER	56
HORIZANT	51	<i>hydroxyurea</i>	14	INVANZ	34
<i>huber safety needles (disp.)</i>	22	<i>hydroxyzine hcl</i>	25	INVEGA	60
HUMALOG	23	<i>hydroxyzine pamoate</i>	25	INVEGA SUSTENNA	60
HUMALOG KWIKPEN	23	<i>ibandronate</i>	70	INVIRASE	5
HUMALOG MIX 50-50	23	<i>ibuprofen</i>	54	INVOKANA	24
HUMALOG MIX 50-50 KWIKPEN	23	<i>ibuprofen-oxycodone</i>	55	IONOSOL-B IN D5W	36
HUMALOG MIX 75-25	23	ICLUSIG	14	IONOSOL-MB IN D5W	36
HUMALOG MIX 75-25 KWIKPEN	23	<i>idarubicin</i>	12	IOPIDINE	28
HUMATROPE	45	IFEX	12	IPOL	42
HUMIRA	53	<i>ifosfamide</i>	12	<i>ipratropium bromide</i>	25
HUMIRA CROHN'S DIS START PCK	53	ILARIS (PF)	43	<i>ipratropium-albuterol</i>	61
HUMULIN 70/30	23	IMBRUVICA	14	<i>irbesartan</i>	17
HUMULIN 70/30 PEN	23	<i>imipenem-cilastatin</i>	34	<i>irbesartan-hydrochlorothiazide</i>	18
HUMULIN N	23	<i>imipramine hcl</i>	58	<i>irinotecan</i>	12
HUMULIN N PEN	23	<i>imipramine pamoate</i>	58	ISENTRESS	5
HUMULIN R	23	<i>imiquimod</i>	67	ISOLYTE S IN 5 % DEXTROSE	36
HUMULIN R U-500 "CONCENTRATED"	23	IMOVAX RABIES VACCINE (PF)	42	ISOLYTE-H IN 5 % DEXTROSE	36
<i>hydralazine</i>	22	INCIVEK	5	ISOLYTE-P IN 5 % DEXTROSE	36
<i>hydrochlorothiazide</i>	20	INCRELEX	45	ISOLYTE-S	36
<i>hydrocodone-acetaminophen</i>	54	<i>indapamide</i>	20	<i>isoniazid</i>	8
<i>hydrocodone-ibuprofen</i>	54	INDOCIN	53	<i>isosorbide dinitrate</i>	16
<i>hydrocortisone</i>	31	<i>indomethacin</i>	53	<i>isosorbide mononitrate</i>	16
<i>hydrocortisone butyrate</i>	65	INFANRIX (DTAP) (PF)	42	<i>isradipine</i>	19
<i>hydrocortisone butyr-emollient</i>	65	INLYTA	14	ISTODAX	12
<i>hydrocortisone valerate</i>	65	INSULIN PEN NEEDLE	22	<i>itraconazole</i>	3
		INSULIN SYRINGE	22	IXEMPRA	13
		INSULIN SYRINGE NEEDLELESS	22	IXIARO (PF)	42
		<i>insulin syringe-needle u-100</i>	22	JAKAFI	14
		INTELENCE	5	JALYN	48
				<i>jantoven</i>	11
				JANUMET	24
				JANUMET XR	24
				JANUVIA	24
				JENTADUETO	24

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

JEVTANA	13	LANTUS	23	<i>lidocaine-prilocaine</i>	
<i>jinteli</i>	68	LANTUS SOLOSTAR			67
<i>junel 1.5/30 (21)</i>			23	LIDODERM	67
	68	<i>larin 1.5/30 (21)</i>		LINCOCIN	34
<i>junel 1/20 (21)</i>			68	<i>lindane</i>	66
	68	LASTACAFT		LINZESS	31
<i>junel fe 1.5/30 (28)</i>			26	<i>liothyronine</i>	40
	68	<i>latanoprost</i>	28	<i>lisinopril</i>	16
<i>junel fe 1/20 (28)</i>		LATUDA	60	<i>lisinopril-hydrochlorothiazide</i>	
	68	LAZANDA	55		18
JUXTAPID	21	<i>leena 28</i>	68	<i>lithium carbonate</i>	
KADCYLA	13	<i>leflunomide</i>	53		57
KALETRA	5	<i>lessina</i>	68	<i>lithium citrate</i>	
KALYDECO	44	LETAIRIS	47		57
<i>kanamycin</i>	34	<i>letrozole</i>	14	LITHOSTAT	48
<i>kariva (28)</i>	68	<i>leucovorin calcium</i>		LO LOESTRIN FE	
<i>kelnor 1/35 (28)</i>			16		68
	68	LEUKERAN	14	LODOSYN	49
KENALOG	65	LEUKINE	10	<i>lokara</i>	65
KETEK	8	<i>leuprolide</i>	13	<i>lomustine</i>	15
<i>ketoconazole</i>	3	<i>levabuterol hcl</i>		<i>loperamide</i>	30
<i>ketoprofen</i>	54		61	<i>lorazepam</i>	56
<i>ketorolac</i>	27	LEVEMIR	23	<i>lorazepam intensol</i>	
KHEDEZLA	58	LEVEMIR FLEXPEN			56
KINERET	53		23	<i>losartan</i>	17
<i>kionex</i>	47	<i>levetiracetam</i>		<i>losartan-hydrochlorothiazide</i>	
<i>klor-con 8</i>	21		51		18
<i>klor-con m10</i>	21	<i>levobunolol</i>	28	LOTEMAX	27
KLOR-CON M15		<i>levocarnitine</i>	30	LOTRONEX	30
	21	<i>levocarnitine (with sugar)</i>		<i>lovastatin</i>	21
<i>klor-con m20</i>	21		30	LOVAZA	21
KRISTALOSE		<i>levocetirizine</i>		<i>low-ogestrel (28)</i>	
	29		25		68
K-TAB	21	<i>levofloxacin</i>	9	<i>loxapine succinate</i>	
KUVAN	46	<i>levofloxacin in d5w</i>			60
KYNAMRO	21		34	LUFYLLIN	62
<i>labetalol</i>	19	<i>levonest (28)</i>	68	LUMIGAN	28
<i>laclotion</i>	66	<i>levonorgestrel-ethinyl estrad</i>		LUMIZYME	46
<i>lactated ringers</i>			68	LUNESTA	59
	34	<i>levora-28</i>	68	LUPRON DEPOT	
<i>lactulose</i>	29	<i>levorphanol tartrate</i>			40
LAMICTAL ODT			55	LUPRON DEPOT (3 MONTH)	
	51	<i>levothroid</i>	40		40
LAMISIL	3	<i>levothyroxine</i>		LUPRON DEPOT (4 MONTH)	
<i>lamivudine</i>	5		40		40
<i>lamivudine-zidovudine</i>		<i>levoxyl</i>	40	LUPRON DEPOT (6 MONTH)	
	5	LEXIVA	5		40
<i>lamotrigine</i>	51	<i>lidocaine</i>	66	LUPRON DEPOT-PED	
LANOXIN	17	<i>lidocaine (pf)</i>			40
LANOXIN PEDIATRIC			34	LUPRON DEPOT-PED (3	
	17	<i>lidocaine hcl</i>	67	MONTH)	40
<i>lansoprazole</i>	30			LUVOX CR	58

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

LYRICA	51	<i>metformin</i>	24	<i>miconazole-3</i>	
LYSODREN	15	<i>methadone</i>	34		71
<i>mafenide acetate</i>		<i>methamphetamine</i>		<i>midodrine</i>	44
	67		57	MIGERGOT	49
<i>magnesium sulfate</i>		<i>methazolamide</i>		MIGRANAL	49
	36		28	MILLIPRED	39
<i>malathion</i>	66	<i>methenamine hippurate</i>		MINASTRIN 24 FE	
<i>maprotiline</i>	58		4		68
<i>marlissa</i>	68	<i>methimazole</i>	40	MINIVELLE	70
MARPLAN	58	METHITEST	39	<i>minocycline</i>	10
MATULANE	15	<i>methotrexate sodium</i>		<i>minoxidil</i>	22
<i>matzim la</i>	19		53	MIRAPEX ER	
MAXIDEX	27	<i>methotrexate sodium (pf)</i>			49
<i>meclizine</i>	28		34	<i>mirtazapine</i>	58
<i>meclofenamate</i>		<i>methoxsalen rapid</i>		<i>misoprostol</i>	30
	53		66	<i>mitomycin</i>	13
<i>medroxyprogesterone</i>		<i>methscopolamine</i>		<i>mitoxantrone</i>	13
	70		30	M-M-R II (PF)	
<i>mefenamic acid</i>		<i>methyclothiazide</i>			42
	54		20	<i>modafinil</i>	59
<i>mefloquine</i>	4	<i>methyldopa</i>	20	MODERIBA	5
<i>megestrol</i>	15	<i>methyldopa-hydrochlorothiazide</i>		MODERIBA DOSE PACK	
MEKINIST	15		18		6
<i>meloxicam</i>	53	<i>methylergonovine</i>		<i>moexipril</i>	16
<i>melphalan</i>	13		70	<i>moexipril-hydrochlorothiazide</i>	
MENACTRA (PF)		METHYLIN	57		18
	42	<i>methylphenidate</i>		<i>mometasone</i>	65
MENEST	70		57	<i>montelukast</i>	62
MENOMUNE - A/C/Y/W-135		<i>methylprednisolone</i>		MONUROL	4
(PF)	42		39	<i>morphine</i>	55
MENOSTAR	70	<i>methylprednisolone acetate</i>		<i>morphine concentrate</i>	
MENTAX	65		39		55
MENVEO A-C-Y-W-135-DIP		<i>methylprednisolone sodium succ</i>		MOVIPREP	30
(PF)	42		39	MOXEZA	26
<i>meprobamate</i>		<i>metipranolol</i>	28	<i>moxifloxacin</i>	9
	56	<i>metoclopramide hcl</i>		MOZOBIL	10
MEPRON	4		28	MULTAQ	17
<i>mercaptapurine</i>		<i>metolazone</i>	20	<i>mupirocin</i>	64
	15	<i>metoprolol succinate</i>		<i>mupirocin calcium</i>	
<i>meropenem</i>	34		19		64
MERREM	34	<i>metoprolol ta-hydrochlorothiaz</i>		MUSTARGEN	
<i>mesna</i>	16		18		13
MESNEX	16	<i>metoprolol tartrate</i>		MYALEPT	30
MESTINON	46		19	MYCAMINE	34
MESTINON TIMESPAN		METROGEL	63	MYCOBUTIN	
	46	<i>metronidazole</i>			8
METADATE CD			4	<i>mycophenolate mofetil</i>	
	56	<i>metronidazole in nacl (iso-os)</i>			43
METADATE ER			34	<i>mycophenolate sodium</i>	
	57	<i>mexiletine</i>	17		43
<i>metaproterenol</i>		MIACALCIN	70	MYFORTIC	43
	62			MYLERAN	15

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

MYOZYME.....	47	NEO-SYNALAR.....	65	<i>nortrel 1/35 (21)</i>	69
MYRBETRIQ.....	48	NEPHRAMINE 5.4 %.....	38	<i>nortrel 1/35 (28)</i>	69
MYTELASE.....	46	<i>neuac</i>	63	<i>nortrel 7/7/7 (28)</i>	69
<i>nabumetone</i>	53	NEULASTA.....	10	<i>nortriptyline</i>	58
<i>nadolol</i>	19	NEUMEGA.....	10	NORVIR.....	6
<i>nadolol-bendroflumethiazide</i>	18	NEUPOGEN.....	10	NOVOLIN 70/30.....	23
<i>nafcillin</i>	34	NEUPRO.....	49	NOVOLIN N.....	23
<i>nafcillin in dextrose iso-osm</i>	34	NEVANAC.....	27	NOVOLIN R.....	23
NAFTIN.....	3	<i>nevirapine</i>	6	NOVOLOG.....	23
NAGLAZYME.....	46	NEXAVAR.....	15	NOVOLOG FLEXPEN.....	23
NALFON.....	53	<i>niacin</i>	21	NOVOLOG MIX 70-30.....	23
<i>naloxone</i>	59	<i>niacor</i>	21	NOVOLOG MIX 70-30 FLEXPEN.....	23
<i>naltrexone</i>	56	<i>nicardipine</i>	19	NOXAFIL.....	3
NAMENDA.....	49	NICOTROL.....	47	NUEDEXTA.....	50
NAMENDA TITRATION PAK.....	49	NICOTROL NS.....	47	NULOJIX.....	43
NAMENDA XR.....	49	<i>nifedical xl</i>	19	NUTROPIN.....	45
<i>naphazoline</i>	26	<i>nifedipine</i>	20	NUTROPIN AQ.....	45
<i>naproxen</i>	54	<i>nikki (28)</i>	69	NUTROPIN AQ NUSPIN.....	45
<i>naproxen sodium</i>	54	NILANDRON.....	15	NUVARING.....	69
<i>naratriptan</i>	49	<i>nimodipine</i>	20	NUVIGIL.....	59
NASONEX.....	25	<i>nisoldipine</i>	20	<i>nyamyc</i>	65
NATACYN.....	28	NITRO-BID.....	16	<i>nystatin</i>	3
<i>nateglinide</i>	24	<i>nitroglycerin</i>	16, 17	<i>nystatin-triamcinolone</i>	65
NEBUPENT.....	4	NITROLINGUAL.....	17	<i>nystop</i>	66
<i>necon 0.5/35 (28)</i>	68	NITROMIST.....	17	<i>octreotide acetate</i>	43
<i>necon 1/35 (28)</i>	68	NITROSTAT.....	17	<i>ofloxacin</i>	9
NECON 10/11 (28).....	69	<i>nizatidine</i>	30	<i>olanzapine</i>	60
<i>necon 7/7/7 (28)</i>	69	<i>nora-be</i>	69	<i>olanzapine-fluoxetine</i>	57
<i>nefazodone</i>	58	NORDITROPIN FLEXPEN.....	45	OLEPTRO ER.....	58
<i>neomycin</i>	4	NORDITROPIN NORDIFLEX.....	45	OLYSIO.....	6
<i>neomycin-bacitracin-poly-hc</i>	26	<i>norethindrone acetate</i>	70	<i>omega-3 acid ethyl esters</i>	21
<i>neomycin-bacitracin-polymyxin</i>	26	NORITATE.....	63	<i>omeprazole</i>	30
<i>neomycin-polymyxin b-dexameth</i>	27	<i>norlyroc</i>	69	<i>omeprazole-sodium bicarbonate</i>	30
<i>neomycin-polymyxin-gramicidin</i>	27	NORMOSOL-M IN 5 %.....	36	OMNITROPE.....	45
<i>neomycin-polymyxin-hc</i>	26	DEXTROSE.....	36	ONCASPAR.....	13
		NORMOSOL-R IN 5 %.....	36	<i>ondansetron</i>	29
		DEXTROSE.....	36		
		NORMOSOL-R PH 7.4.....	36		
		NOROXIN.....	9		
		NORPACE CR.....	17		
		<i>nortrel 0.5/35 (28)</i>	69		

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<i>ondansetron hcl</i>	29	<i>oxycodone</i>	55	<i>perindopril erbumine</i>	16
<i>ondansetron hcl (pf)</i>	34	<i>oxycodone-acetaminophen</i>	55	<i>perio gard</i>	25
ONE TOUCH TEST	22	<i>oxycodone-aspirin</i>	55	PERJETA	13
ONE TOUCH ULTRA TEST	22	OXYCONTIN	55	<i>permethrin</i>	66
ONE TOUCH VERIO	22	<i>oxymorphone</i>	55	<i>perphenazine</i>	60
ONFI	51	OXYTROL	48	<i>perphenazine-amitriptyline</i>	60
OPSUMIT	47	PACERONE	17	PERTZYE	29
ORAP	60	<i>paclitaxel</i>	13	PEXEVA	58
ORAPRED	39	<i>pamidronate</i>	34	PFIZERPEN-G	35
ORAPRED ODT	39	PANCREAZE	29	<i>phenelzine</i>	58
ORENCIA	53	PANDEL	65	<i>phenobarbital</i>	51
ORENCIA (WITH MALTOSE)	53	PANRETIN	67	<i>phenytoin</i>	51
ORENITRAM	62	<i>pantoprazole</i>	30	<i>phenytoin sodium</i>	51
ORFADIN	45	<i>paricalcitol</i>	46	<i>phenytoin sodium extended</i>	51
<i>orsythia</i>	69	<i>paromomycin</i>	4	PHOSLYRA	47
ORTHO EVRA	69	<i>paroxetine hcl</i>	58	PICATO	67
ORTHO TRI-CYCLEN (28)	69	PASER	8	<i>pilocarpine hcl</i>	25
OSMOPREP	30	PAXIL	58	<i>pindolol</i>	19
OTEZLA	53	PCE	8	<i>pioglitazone</i>	24
OTEZLA STARTER	53	<i>pedi-dri</i>	66	<i>pioglitazone-glimepiride</i>	24
OTREXUP (PF)	53	PEDVAX HIB (PF)	42	<i>pioglitazone-metformin</i>	24
OVCON-50 (28)	69	PEGANONE	51	<i>piperacillin-tazobactam</i>	35
<i>oxacillin</i>	34	PEGASYS	6	<i>piroxicam</i>	53
<i>oxacillin in dextrose(iso-osm)</i>	34	PEGASYS PROCLICK	6	PLASMA-LYTE 148	36
<i>oxaliplatin</i>	13	PEGINTRON	6	PLASMA-LYTE A	36
<i>oxandrolone</i>	39	PEGINTRON REDIPEN	6	PLASMA-LYTE-56 IN 5 %	36
<i>oxazepam</i>	56	<i>penicillin g pot in dextrose</i>	35	DEXTROSE	36
<i>oxcarbazepine</i>	51	<i>penicillin g potassium</i>	35	<i>pneumovax 23</i>	42
OXISTAT	66	<i>penicillin g sodium</i>	35	<i>podofilox</i>	67
OXSORALEN	66	<i>penicillin v potassium</i>	8	<i>polyethylene glycol 3350</i>	30
OXSORALEN ULTRA	66	PENNSAID	53	<i>polymyxin b sulfate</i>	35
OXTELLAR XR	51	PENTAM	4	<i>polymyxin b sulf-trimethoprim</i>	26
<i>oxybutynin chloride</i>	48	PENTASA	31	POMALYST	15
		<i>pentoxifylline</i>	11	<i>portia</i>	69
		PERFOROMIST	62		

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

<i>potassium chlorid-d5-0.45%nacl</i>	<i>prevnar 13 (pf)</i>	<i>protriptyline</i>	58
..... 36	..... 42	PROVENTIL HFA	62
<i>potassium chloride</i>	PREVPAC	.....	62
..... 22	PREZISTA	<i>prudoxin</i>	67
<i>potassium chloride in 0.9%nacl</i>	PRIFTIN	PULMICORT	62
..... 37	<i>primaquine</i>	.....	62
<i>potassium chloride in 5 % dex</i>	PRIMAXIN IV	PULMICORT FLEXHALER	62
..... 37	..... 35	.....	62
<i>potassium chloride in lr-d5</i>	<i>primidone</i>	PULMOZYME	44
..... 37	PRIMSOL	.....	44
<i>potassium chloride-0.45 % nacl</i>	PRIVIGEN	PYLERA	30
..... 37	PROAIR HFA	<i>pyrazinamide</i>	9
<i>potassium chloride-d5-0.2%nacl</i>	..... 62	.....	9
..... 37	<i>probenecid</i>	<i>pyridostigmine bromide</i>	46
<i>potassium chloride-d5-0.3%nacl</i>	PROCALAMINE 3%	.....	46
..... 37	..... 38	<i>quasense</i>	69
<i>potassium chloride-d5-0.9%nacl</i>	<i>prochlorperazine</i>	QUDEXY XR	51
..... 37	..... 29	.....	51
<i>potassium citrate</i>	<i>prochlorperazine edisylate</i>	<i>quetiapine</i>	60
..... 48	..... 29	QUILLIVANT XR	57
POTIGA	<i>prochlorperazine maleate</i>	.....	57
..... 51	..... 29	<i>quinapril</i>	16
PRADAXA	PROCRIT	<i>quinapril-hydrochlorothiazide</i>	18
..... 11	..... 10	.....	18
<i>pramipexole</i>	<i>proctocream-hc</i>	<i>quinidine gluconate</i>	17
PRANDIMET	..... 67	.....	17
..... 24	<i>proctosol hc</i>	<i>quinidine sulfate</i>	17
PRANDIN	..... 67	.....	17
..... 24	<i>progesterone micronized</i>	<i>quinine sulfate</i>	4
<i>pravastatin</i>	..... 71	.....	4
..... 21	PROGLYCEM	QVAR	62
<i>prazosin</i>	..... 22	RABAVERT (PF)	42
..... 16	PROGRAF	.....	42
PRED MILD	..... 35	<i>rabeprazole</i>	30
..... 27	PROLASTIN-C	RAGWITEK	42
PRED-G	..... 62	.....	42
..... 27	PROLENSA	<i>raloxifene</i>	71
PRED-G S.O.P.	PROLEUKIN	<i>ramipril</i>	16
..... 27	..... 13	RANEXA	17
<i>prednicarbate</i>	PROLIA	<i>ranitidine hcl</i>	30
..... 65	..... 62	.....	30
<i>prednisolone acetate</i>	PROLENSA	RAPAMUNE	43
..... 27	PROLEUKIN	REBETOL	6
<i>prednisolone sodium phosphate</i>	..... 13	REBIF (WITH ALBUMIN)	46
..... 39	PROMACTA	.....	46
<i>prednisone</i>	..... 10	RECLAST	71
..... 39	<i>propafenone</i>	RECOMBIVAX HB (PF)	42
PREDNISONE INTENSOL	<i>propantheline</i>	.....	42
..... 39	..... 30	REGRANEX	67
PREMARIN	<i>propranolol</i>	RELENZA DISKHALER	6
..... 70	..... 19	.....	6
PREMASOL 10 %	<i>propranolol-hydrochlorothiazid</i>	REBIF TITRATION PACK	46
..... 38	..... 18	.....	46
PREMASOL 6 %	<i>propylthiouracil</i>	.....	46
..... 38	..... 40	RELAST	71
PREMPHASE	PROQUAD (PF)	.....	71
..... 70	..... 42	RECOMBIVAX HB (PF)	42
PREMPRO	PROSOL 20 %	.....	42
..... 71	..... 38	REGRANEX	67
<i>prenatal vitamin</i>	PROTONIX	.....	67
..... 71	..... 35	RELENZA DISKHALER	6
PREVALITE	PROTOPIC	.....	6
..... 21	..... 67	.....	6

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

RELISTOR.....	30	SAMSCA.....	48	<i>sodium lactate</i>	
REMICADE.....	53	SANCUSO.....	29		37
REMODULIN.....		SANDOSTATIN.....		<i>sodium polystyrene (sorb free)</i>	
	47		43		47
RENAGEL.....	47	SANDOSTATIN LAR DEPOT.....		SOLARAZE.....	67
REVELA.....	47		43	SOLTAMOX.....	15
<i>repaglinide</i>	24	SANTYL.....	67	SOLU-CORTEF (PF).....	
RESCRIPTOR.....		SAPHRIS (BLACK CHERRY).....			39
	6		60	SOLU-MEDROL (PF).....	
<i>reserpine</i>	20	SAVELLA.....	51		39
RESTASIS.....	28	<i>selegiline hcl</i>	49	SOMATULINE DEPOT.....	
RETIN-A.....	63	<i>selenium sulfide</i>			43
RETIN-A MICRO.....			67	SOMAVERT.....	43
	63	SELZENTRY.....		SORIATANE.....	
RETIN-A MICRO PUMP.....			6		66
	63	SENSIPAR.....	45	<i>sorine</i>	17
RETROVIR.....	35	SEREVENT DISKUS.....		<i>sotalol</i>	17
REVATIO.....	47		62	<i>sotalol af</i>	17
REVLIMID.....	15	SEROMYCIN.....		SOVALDI.....	6
REYATAZ.....	6		9	SPECTRACEF.....	
<i>ribapak dose pack</i>		SEROQUEL XR.....			8
	6		60	SPIRIVA WITH HANDIHALER.....	
<i>ribasphere</i>	6	SEROSTIM.....	45		62
<i>ribavirin</i>	6	<i>sertraline</i>	58	<i>spironolactone</i>	
RIDAURA.....	53	SFROWASA.....	31		20
<i>rifabutin</i>	9	SIGNIFOR.....	44	<i>spironolacton-hydrochlorothiaz</i>	
RIFAMATE.....	9	SILDENAFIL.....			20
<i>rifampin</i>	9		47	SPRYCEL.....	15
RIFATER.....	9	<i>silver sulfadiazine</i>		<i>ssd</i>	64
RILUTEK.....	43		64	STALEVO 100.....	
<i>riluzole</i>	43	SIMBRINZA.....	28		50
<i>rimantadine</i>	6	SIMCOR.....	21	STALEVO 125.....	
<i>ringers</i>	37	SIMPONI.....	53		50
RIOMET.....	24	SIMPONI ARIA.....		STALEVO 150.....	
<i>risedronate</i>	71		53		50
RISPERDAL CONSTA.....		SIMULECT.....	43	STALEVO 200.....	
	57	<i>simvastatin</i>	21		50
<i>risperidone</i>	57	<i>sirolimus</i>	43	STALEVO 50.....	
RITUXAN.....	13	SIRTURO.....	9		50
<i>rivastigmine tartrate</i>		SKLICE.....	66	STALEVO 75.....	
	49	<i>sodium chloride</i>			50
<i>rizatriptan</i>	49		37	<i>stavudine</i>	6
<i>ropinirole</i>	49	<i>sodium chloride 0.45 %</i>		STAVZOR.....	51
ROTATEQ VACCINE.....			37	STELARA.....	66
	42	<i>sodium chloride 0.9 %</i>		STIMATE.....	11
ROXICET.....	55		37	STIVARGA.....	15
ROZEREM.....	59	<i>sodium chloride 3 %</i>		STRATTERA.....	
SABRIL.....	51		37		57
SAFYRAL.....	69	<i>sodium chloride 5 %</i>		<i>streptomycin</i>	35
SAIZEN.....	45		37	STRIANT.....	39
SAIZEN CLICK.EASY.....		<i>sodium fluoride</i>		STRIBILD.....	6
	45		25		

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STROMECTOL	4	TARGRETIN	15	THYROLAR-1/4	40
SUBOXONE	59	TARKA	18	THYROLAR-2	40
SUBSYS	55	TASIGNA	15	THYROLAR-3	40
SUCLEAR	30	TASMAR	50	<i>tiagabine</i>	51
<i>sucralfate</i>	31	TAXOTERE	13	<i>ticlopidine</i>	11
<i>sulfacetamide sodium</i>	26	TAZORAC	66	TIKOSYN	17
<i>sulfacetamide sodium (acne)</i>	67	<i>taztia xt</i>	20	TIMENTIN	35
<i>sulfacetamide-prednisolone</i>	26	TECFIDERA	46	<i>timolol maleate</i>	19
<i>sulfadiazine</i>	9	TEFLARO	35	<i>tinidazole</i>	4
<i>sulfamethoxazole-trimethoprim</i>	9	TEGRETOL XR	51	TIROSINT	40
SULFAMYLON	67	TEKAMLO	18	TIVICAY	7
<i>sulfasalazine</i>	31	TEKURNA	20	<i>tizanidine</i>	52
<i>sulfazine ec</i>	31	TEKURNA HCT	18	TOBI	44
<i>sulindac</i>	53	<i>telmisartan</i>	17	TOBI PODHALER	44
<i>sumatriptan</i>	49	<i>telmisartan-amlodipine</i>	18	TOBRADEX	26
<i>sumatriptan succinate</i>	49	<i>telmisartan-hydrochlorothiazid</i>	18	TOBRADEX ST	26
SUMAVEL DOSEPRO	49	<i>temazepam</i>	59	<i>tobramycin</i>	26
SUPRAX	8	TEMODAR	15	<i>tobramycin in 0.225 % nacl</i>	44
SUPREP	30	<i>temozolomide</i>	15	<i>tobramycin in 0.9 % nacl</i>	35
SUSTIVA	6	<i>terazosin</i>	16	<i>tobramycin sulfate</i>	35
SUTENT	15	<i>terbinafine hcl</i>	3	<i>tobramycin sulfite</i>	35
SYLATRON	13	<i>terbutaline</i>	62	<i>tobramycin-dexamethasone</i>	26
SYLVANT	44	<i>terconazole</i>	71	<i>tolazamide</i>	24
SYMBICORT	62	<i>testosterone cypionate</i>	39	<i>tolbutamide</i>	24
SYMLINPEN 120	23	<i>testosterone enanthate</i>	40	<i>tolmetin</i>	53
SYMLINPEN 60	23	TESTRED	40	<i>tolterodine</i>	48
SYNAGIS	47	<i>tetanus toxoid,adsorbed (pf)</i>	42	<i>topiramate</i>	51
SYNAREL	40	<i>tetanus-diphtheria toxoids-td</i>	42	<i>toposar</i>	13
SYNERA	67	<i>tetracycline</i>	10	<i>topotecan</i>	13
SYNERCID	35	TEV-TROPIN	45	TORISEL	13
SYNRIBO	13	THALOMID	15	<i>torseamide</i>	20
SYNTHROID	40	<i>theophylline</i>	62	<i>tpn electrolytes</i>	38
SYPRINE	48	<i>thioridazine</i>	60	TRACLEER	47
TABLOID	15	<i>thiothixene</i>	60	TRADJENTA	24
<i>tacrolimus</i>	43	THYMOGLOBULIN	42	<i>tramadol</i>	55
TAFINLAR	15	THYROLAR-1	40	<i>tramadol-acetaminophen</i>	56
TAMIFLU	6, 7	THYROLAR-1/2	40	<i>trandolapril</i>	16
<i>tamoxifen</i>	15			<i>tranexamic acid</i>	11
<i>tamsulosin</i>	48				
TARCEVA	15				

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TRANSDERM-SCOP		TUDORZA PRESSAIR		<i>venlafaxine</i>	59
	29		62	VENTAVIS	62
<i>tranylcypromine</i>		TWINJECT AUTOINJECTOR		VENTOLIN HFA	
	58		44		62
TRAVASOL 10 %		TWINRIX (PF)		<i>verapamil</i>	20
	38		42	VERIPRED 20	
TRAVATAN Z		TYGACIL			39
	28	TYKERB		VERSACLOZ	
<i>travoprost (benzalkonium)</i>		TYPHIM VI			60
	28	TYSABRI		VESICARE	48
<i>trazodone</i>		TYVASO		VEXOL	27
TREANDA	13	TYZEKA	7	VFEND	3
TRECTOR	9	TYZINE	25	VFEND IV	35
TRELSTAR	43	UCERIS	31	VIBATIV	35
<i>tretinoin</i>	63	<i>u-cort</i>	65	VIBRAMYCIN	
<i>tretinoin (chemotherapy)</i>		ULESFIA	66		10
	15	ULORIC	53	VICTOZA 3-PAK	
TRETIN-X CREAM KIT		ULTRESA	29		23
	63	<i>unithroid</i>	40	VICTRELIS	7
TREXALL	53	UROCIT-K 10		VIDAZA	13
<i>triamcinolone acetonide</i>			48	VIDEX 2 GRAM PEDIATRIC	
	25	UROCIT-K 15			7
<i>triamterene-hydrochlorothiazid</i>			48	VIGAMOX	26
	18	UROCIT-K 5	48	VIIBRYD	59
<i>triazolam</i>	59	<i>ursodiol</i>	30	VIMPAT	52
<i>triderm</i>	65	UVADEX	13	<i>vinblastine</i>	13
<i>trifluoperazine</i>		VAGIFEM	71	<i>vincasar pfs</i>	13
	60	<i>valacyclovir</i>	7	<i>vincristine</i>	13
<i>trifluridine</i>	27	VALCYTE	7	<i>vinorelbine</i>	13
<i>trihexyphenidyl</i>		<i>valproate sodium</i>		VIOKACE	29
	50		35	VIRACEPT	7
<i>trilyte with flavor packets</i>		<i>valproic acid</i>	51	VIRAMUNE	7
	30	<i>valproic acid (as sodium salt)</i>		VIRAMUNE XR	
<i>trimethoprim</i>	4		52		7
<i>trimipramine</i>	58	<i>valsartan</i>	17	VIREAD	7
<i>trinessa (28)</i>	69	<i>valsartan-hydrochlorothiazide</i>		VISTIDE	35
<i>tri-previfem (28)</i>			18	VIVACTIL	59
	69	VANCOGIN	4	VIVELLE-DOT	
TRISENOX	13	<i>vancomycin</i>	4		71
<i>tri-sprintec (28)</i>		<i>vandazole</i>	71	VIVOTIF BERNA VACCINE	
	69	VANOS	65		42
<i>trivora (28)</i>	69	VAQTA (PF)	42	VOLTAREN	53
TRIZIVIR	7	VARIVAX (PF)		<i>voriconazole</i>	3
TROKENDI XR			42	VOSOL-HC	25
	51	VECTIBIX	13	VOTRIENT	15
TROPHAMINE 10 %		VELCADE	13	VPRIV	45
	38	VELETRI	47	<i>vyfemla (28)</i>	69
TROPHAMINE 6%		<i>velivet triphasic regimen (28)</i>		VYTORIN 10-10	
	38		69		21
<i>tropium</i>	48	VELPHORO	47	VYTORIN 10-20	
TRUVADA	7	VENLAFAXINE			21
			59		

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

VYTORIN 10-40	21	ZIOPTAN (PF)	28
VYTORIN 10-80	21	<i>ziprasidone hcl</i>	60
VYVANSE	57	ZIRGAN	27
<i>warfarin</i>	11	ZMAX	8
<i>water for irrigation, sterile</i>	67	<i>zoledronic acid</i>	71
WELCHOL	21	<i>zoledronic acid-mannitol-water</i>	71
XALKORI	15	ZOLINZA	15
XARELTO	11	<i>zolmitriptan</i>	49
XARTEMIS XR	56	<i>zolpidem</i>	59
XELJANZ	53	ZOLPIMIST	59
XELODA	15	ZOMETA	71
XENAZINE	45	ZONALON	67
XGEVA	71	<i>zonisamide</i>	52
XIFAXAN	4	ZORBTIVE	45
XOLAIR	62	ZORTRESS	43
XOPENEX HFA	62	ZOSTAVAX (PF)	42
XTANDI	15	ZOSYN	35
<i>xulane</i>	71	ZOSYN IN DEXTROSE	36
XYREM	59	(ISO-OSM)	36
YERVOY	13	<i>zovia 1/35e (28)</i>	69
YF-VAX (PF)	42	<i>zovia 1/50e (28)</i>	69
<i>zafirlukast</i>	62	ZOVIRAX	67
<i>zaleplon</i>	59	ZUBSOLV	59
ZALTRAP	14	ZYDELIG	15
ZANOSAR	14	ZYKADIA	16
ZAVESCA	45	ZYLET	27
<i>zazole</i>	71	ZYMAXID	26
ZELBORAF	15	ZYPREXA	60
ZEMAIRA	62	ZYTIGA	16
ZEMPLAR	35	ZYVOX	4
ZENCHENT (28)	69		
ZENCHENT FE	69		
ZENPEP	29		
<i>zeosa</i>	69		
ZERIT	7		
ZETIA	21		
ZIAGEN	7		
<i>zidovudine</i>	7		
ZINACEF IN DEXTROSE	35		
(ISO-OSM)	35		
ZINACEF IN STERILE WATER	35		
ZINECARD (AS HCL)	16		

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

This formulary was updated on January 1, 2014. For more recent information or other questions, please contact Tufts Medicare Preferred HMO Customer Relations at 1-800-701-9000 or, for TTY users, 1-800-208-9562, Monday - Friday 8:00 a.m. - 8:00 p.m. (from Oct. 1 - Feb. 14 representatives are available 7 days a week, 8:00 a.m. - 8:00 p.m.). After hours and on holidays, please leave a message and a representative will return your call on the next business day. Or visit tuftsmedicarepreferred.org.

Tufts Health Plan Medicare Preferred is an HMO plan with a Medicare contract. Enrollment in Tufts Health Plan Medicare Preferred depends on contract renewal.

This information is available for free in other languages. Please call our Customer Relations number at 1-800-701-9000 or, for TTY users, 1-800-208-9562, Monday - Friday 8:00 a.m. - 8:00 p.m. (from Oct. 1 - Feb. 14 representatives are available 7 days a week, 8:00 a.m. - 8:00 p.m.). After hours and on holidays, please leave a message and a representative will return your call on the next business day.

Esta información está disponible gratuitamente en otros idiomas. Sírvase llamar a nuestro número de Servicio al Cliente al 1-800-701-9000 o, para usuarios con problemas auditivos (TTY), al 1-800-208-9562, de lunes a viernes, desde las 8:00 a.m. hasta las 8:00 p.m. (desde el 1 de octubre hasta el 14 de febrero hay representantes disponibles los 7 días de la semana, desde las 8:00 a.m. hasta las 8:00 p.m.). Después del horario de atención y en días feriados, por favor deje un mensaje y un representante le devolverá su llamada el día laborable siguiente.

TUFTS  **Health Plan**
Medicare Preferred

705 Mount Auburn Street, Watertown, MA 02472