# Express Scripts Medicare (PDP)
# 2022 Formulary (List of Covered Drugs)

## PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT SOME OF THE DRUGS COVERED BY THIS PLAN

Formulary ID Number: 22039, v7

This formulary was updated on 08/24/2021. For more recent information or to price a medication, you can visit us on the Web at **express-scripts.com**. Or you can contact **Express Scripts Medicare®** (PDP) Customer Service at the numbers located on the back of your member ID card. Customer Service is available 24 hours a day, 7 days a week.

**Note to current members:** This formulary has changed since last year. Please review this document to understand your plan's drug coverage.

When this drug list (formulary) refers to "we," "us" or "our," it means *Medco Containment Life Insurance Company* or *Medco Containment Insurance Company of New York (for employer plans domiciled in New York)*. When it refers to "plan" or "our plan," it means *Express Scripts Medicare*.

This document includes the list of the covered drugs (formulary) for our plan, which is current as of August 24, 2021. For more recent information, please contact us. Our contact information, along with the date we last updated the formulary, appears above and on the back cover.

You must use network pharmacies to fill your prescriptions to get the most from your benefit. Benefits, premium and/or copayments/coinsurance may change on January 1, 2023. The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1.800.268.5707** (TTY: **1.800.716.3231**).

This document is available in braille. Please contact Customer Service if you need plan information in another format.

## What is the Express Scripts Medicare formulary?

The list of drugs covered by the plan is also known as the "formulary." It contains a list of covered Medicare Part D drugs selected by Express Scripts Medicare 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. The formulary also includes information on requirements or limits for some covered drugs that are part of Express Scripts Medicare's standard formulary rules. **Your specific plan may provide coverage of additional drugs that are not listed in this formulary, and your plan may have different plan rules and coverage.** For more information on your plan's specific drug coverage, please review your other plan materials, visit us on the Web at **express-scripts.com** or contact Customer Service.

Express Scripts Medicare will cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at an Express Scripts Medicare network pharmacy and other plan rules are followed. For more information on how to fill your prescriptions, please review your other plan materials.

## Can my drug coverage change?

Most changes in drug coverage happen on January 1, but we may add or remove drugs on the drug list during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow Medicare rules in making these changes.

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

- **New generic drugs.** We may immediately remove a brand-name drug on our formulary if we are replacing it with a new generic drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand-name drug on our formulary, but immediately move it to a different cost-sharing tier or add new restrictions. If you are currently taking that brand-name drug, we may not tell you in advance before we make that change, but we will later provide you with information about the specific change(s) we have made.
    - If we make such a change, you or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled "How do I request an exception to the formulary?"

- **Drugs removed from the market.** 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.

- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to market to replace a brand-name drug currently on the formulary or add new restrictions to the brand-name drug or move it to a different cost-sharing tier or both. Or we may make changes based on new clinical guidelines. 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, if applicable, we must notify affected members of the change at least 30 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 one-month supply of the drug.

This drug list was updated in August 2021.

- If we make these other changes, you or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled "How do I request an exception to the formulary?"

**Changes that will not affect you if you are currently taking the drug.** Generally, if you are taking a drug on our 2022 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2022 coverage year except as described above. This means these drugs will remain available at the same cost-sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

To get current information about the drugs covered by our plan, please contact us. Our contact information appears on the front and back covers.

## How do I use the formulary?

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

**Medical Condition**

The formulary begins on page 1. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category "Cardiovascular, Hypertension/Lipids."

**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 78. 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 "Drug Name" column of the list.

## What are generic drugs?

Both brand-name drugs and generic drugs are covered under this plan. A generic drug is approved by the FDA as having the same active ingredient(s) 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:** You or your doctor is required to get prior authorization for certain drugs. This means that you will need to get approval from the plan before you fill your prescriptions. If you don't get approval, the drugs may not be covered. These drugs are noted with "PA" next to them in the formulary.

  Some drugs may be covered under Part B or under Part D, depending on your medical condition. Your doctor will need to get a prior authorization for these drugs as well, so your pharmacy can process your prescription correctly.

- **Quantity Limits:** For certain drugs, the amount of the drug that will be covered by the plan is limited. The plan may limit how much of a drug you can get each time you fill your

prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day. These drugs are noted with "QL" next to them in the formulary.

- **Step Therapy:** In some cases, you are required to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B. These drugs are noted with "ST" next to them in the formulary.

You may be able to find out if your drug has any additional requirements or limits by looking in the drug list that begins on page 1. Note: This drug list includes all possible restrictions and limits on coverage. **The requirements and limits may not apply to your plan's specific coverage.** To confirm whether a particular drug is covered, visit us on the Web at **express-scripts.com** or contact Customer Service.

You can ask us to make an exception to these restrictions or limits. See the section "How do I request an exception to the 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 list of covered drugs, you should first contact Customer Service and ask if your drug is covered.

If you learn that your drug is not covered, you have two options:

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

You should talk to your doctor to decide if you should switch to an appropriate drug that the plan covers or request a formulary exception so that the plan will cover the drug you are taking.

## How do I request an exception to the formulary?

You can ask us 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 your drug even if it is not on our formulary. If approved, the drug will be covered at a pre-determined cost-sharing level, and you will 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 approved, this would lower the amount you must pay for your drug. In certain Express Scripts Medicare plans, you cannot ask us to change the cost-sharing tier for any drug in the specialty tier, if applicable.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, Express Scripts Medicare limits the amount of the drug it will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

This drug list was updated in August 2021.

You should contact us to ask for an initial coverage decision for a formulary, tier or utilization restriction exception. **When you are requesting an 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 believes 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.

Generally, your request for an exception will only be approved if the alternative drugs that are included in the plan formulary, the lower-tiered drugs or the additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

## How do I request an appeal?

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. To start an appeal, you, your doctor or your representative must contact us.

When you make an appeal, we review the coverage decision we have made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review, we give you our decision.

For more information about the appeals process, you may contact Customer Service using the information provided on the front and back covers of this document.

## Can I get a temporary transition supply while I wait for an exception decision?

As a new or continuing member in our plan, you may be taking drugs that are not covered from one year to the next. Or, you may be taking a drug that is covered 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, or while you wait for a coverage decision from us, we may cover a temporary transition supply of your drug in certain cases during the first 90 days that you are enrolled in the plan or at the start of a new coverage year.

For each of your drugs that is not on our formulary, or if your ability to get drugs is limited, we will cover a temporary transition supply when you go to a network pharmacy. This temporary transition supply will be for a one-month supply. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum of a one-month supply of medication. After your first refill of a one-month supply, we will not pay for these drugs, even if you have been a plan member less than 90 days.

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

Other times when we will cover at least a temporary 30-day transition supply (or less, if you have a prescription written for fewer days) include

- When you enter a long-term care facility
- When you leave a long-term care facility

This drug list was updated in August 2021.

- When you are discharged from a hospital
- When you leave a skilled nursing facility
- When you cancel hospice care
- When you are discharged from a psychiatric hospital with a medication regimen that is highly individualized

Express Scripts Medicare will send you a letter within 3 business days of your filling a temporary transition supply notifying you that this was a temporary supply and explaining your options.

## Other coverage that your plan may provide

Your plan **may** also cover categories of "excluded" drugs that are not normally covered by a Medicare prescription drug plan and are not listed in the formulary. **Drugs in the following categories may be covered subject to the rules and limitations of your specific plan:**

- Prescription drugs when used for anorexia, weight loss or weight gain
- Prescription drugs when used to promote fertility
- Prescription drugs when used for cosmetic purposes or to promote hair growth
- Prescription drugs when used for the symptomatic relief of cough or colds
- Prescription vitamins and mineral products (except prenatal vitamins and fluoride preparations, which are considered Part D drugs)
- Drugs when used for the treatment of sexual or erectile dysfunction
- Over-the-counter (OTC) diabetic supplies
- Federal Legend Part B medications – for example, oral chemotherapy agents (e.g., TEMODAR®, XELODA®)
- Non-prescription drugs, also known as over-the-counter (OTC) drugs
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale.

Please contact Customer Service for additional information about your plan's specific drug coverage and your cost-sharing amount. **Please note:** Costs for excluded drugs not normally covered by a Medicare prescription drug plan will not count toward your Medicare prescription drug yearly deductible (if applicable), total drug costs or yearly out-of-pocket expenses.

## Formulary

The formulary that begins on page 1 provides coverage information about some of the drugs covered by this plan. If you have trouble finding your drug in the list, turn to the Index that begins on page 78.

The "Drug Name" column of the chart lists the drug name. Brand-name drugs are capitalized (e.g., CRESTOR®) and generic drugs are listed in lowercase italics (e.g., *atorvastatin*). The information in the "Requirements/Limits" column tells you if there are any special requirements for coverage of that particular drug.

**If you are not sure whether your drug is covered, please visit our website or contact Customer Service using the information provided on the front and back covers of this formulary.**

This drug list was updated in August 2021.

## Your Costs

The amount you pay for a covered drug will depend on:

- **Your coverage stage.** Your plan has different stages of coverage. In each stage, the amount you pay for a drug may change. Please refer to your other plan documents for more information about your specific prescription drug benefit.
- **The drug tier for your drug.** Each covered drug is in one of four drug tiers. Each tier may have a different cost-sharing amount. The "Drug Tiers" chart below explains what types of drugs are included in each tier and shows how costs may change with each tier.

Your other plan materials have more information about your plan's coverage stages and list the specific cost-sharing amounts for each tier.

## Drug Tiers

| Tier | Includes | Helpful tips |
|---|---|---|
| Tier 1: **Generic Drugs** | This tier includes many commonly prescribed generic drugs and may include other low-cost drugs. | Use Tier 1 drugs for the lowest cost-sharing amount. |
| Tier 2: **Preferred Brand Drugs** | This tier includes preferred brand-name drugs as well as some generic drugs. | Drugs in this tier will generally have lower cost-sharing amounts than non-preferred drugs. |
| Tier 3: **Non-Preferred Drugs** | This tier includes non-preferred brand-name drugs as well as some generic drugs. | Many non-preferred drugs have lower-cost alternatives in Tiers 1 and 2. Ask your doctor if switching to a lower-cost generic or preferred brand-name drug may be right for you. |
| Tier 4: **Specialty Tier Drugs** | This tier includes very high cost brand-name and generic drugs. | To learn more about medications in this tier, you may contact a pharmacist using the information provided on the front and back covers of this formulary. |

## If you qualify for Extra Help

If you qualify for Extra Help from Medicare to help pay for your prescription drugs, your cost-sharing amounts may be lower than your plan's standard benefit. Members who qualify for Extra Help will receive a notice called "Important Information for Those Who Receive Extra Help Paying for Their Prescription Drugs" ("Low Income Rider" or "LIS Rider"). Please read it to find out what your costs are. You can also contact Customer Service with any questions using the information listed on the front and back covers of this formulary.

## For more information

For more detailed information about your Medicare prescription drug coverage and your plan's specific costs, please review your other plan materials.

If you need additional information on network pharmacies or if you have any other questions, please contact our Customer Service department using the information provided on the front and back covers of this formulary.

This drug list was updated in August 2021.

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 https://www.medicare.gov.

Below is a list of abbreviations that may appear on the following pages in the "Requirements/Limits" column that tells you if there are any special requirements for coverage of your drug.

**Note:** The following drug list includes all possible restrictions and limitations. **Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list.** To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at **express-scripts.com**.

## List of abbreviations

**LA:** Limited Availability. This prescription drug may be available only at certain pharmacies. For more information, contact Customer Service using the information provided on the front and back covers of this formulary.

**MO:** Mail-Order Drug. This prescription drug is available through Express Scripts® Pharmacy, our home delivery service, as well as through select retail network pharmacies. It may also be available through other network pharmacies. Consider using our home delivery service for your long-term (maintenance) medications, such as high blood pressure medications. Retail network pharmacies may be more appropriate for short-term prescriptions, such as antibiotics.

**PA:** Prior Authorization. The plan requires you or your doctor to get prior authorization for certain drugs. This means that you will need to get approval before you fill your prescription. If you don't get approval, we may not cover this drug.

**QL:** Quantity Limit. For certain drugs, the plan limits the amount of the drug that we will cover.

**ST:** Step Therapy. In some cases, the plan requires you to first try a certain drug to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B.

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **ANTI - INFECTIVES** | | |
| **ANTIFUNGAL AGENTS** | | |
| ABELCET | 3 | PA; MO |
| AMBISOME | 4 | PA; MO |
| *amphotericin b* | 1 | PA; MO |
| *caspofungin intravenous recon soln 50 mg* | 4 | PA |
| *caspofungin intravenous recon soln 70 mg* | 1 | PA |
| *clotrimazole mucous membrane* | 1 | MO |
| CRESEMBA ORAL | 4 | PA |
| *fluconazole* | 1 | MO |
| *fluconazole in nacl (iso-osm) intravenous piggyback 200 mg/100 ml* | 1 | PA; MO |
| *fluconazole in nacl (iso-osm) intravenous piggyback 400 mg/200 ml* | 1 | PA |
| *flucytosine* | 4 | MO |
| *griseofulvin microsize* | 1 | MO |
| *griseofulvin ultramicrosize* | 1 | MO |
| *itraconazole oral capsule* | 1 | MO; QL (120 per 30 days) |
| *itraconazole oral solution* | 1 | MO |
| *ketoconazole oral* | 1 | MO |
| *micafungin* | 4 | MO |
| NOXAFIL ORAL SUSPENSION | 4 | PA; MO; QL (630 per 30 days) |
| *nystatin oral* | 1 | MO |
| *posaconazole oral tablet,delayed release (dr/ec)* | 4 | PA; MO; QL (96 per 30 days) |
| *terbinafine hcl oral* | 1 | MO |
| *voriconazole intravenous* | 4 | PA; MO |
| *voriconazole oral suspension for reconstitution* | 4 | PA; MO |
| *voriconazole oral tablet* | 1 | PA; MO |
| **ANTIVIRALS** | | |
| *abacavir* | 1 | MO |
| *abacavir-lamivudine* | 1 | MO |
| *abacavir-lamivudine-zidovudine* | 4 | MO |
| *acyclovir oral capsule* | 1 | MO |
| *acyclovir oral suspension 200 mg/5 ml* | 1 | MO |

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at **express-scripts.com**.

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *acyclovir oral tablet* | 1 | MO |
| *acyclovir sodium intravenous solution* | 1 | PA; MO |
| *adefovir* | 1 | MO |
| *amantadine hcl* | 1 | MO |
| APTIVUS | 4 | MO |
| *atazanavir* | 1 | MO |
| BARACLUDE ORAL SOLUTION | 4 | MO |
| BIKTARVY | 4 | MO |
| COMPLERA | 4 | MO |
| DELSTRIGO | 4 | MO |
| DESCOVY | 4 | MO |
| DOVATO | 4 | MO |
| EDURANT | 4 | MO |
| *efavirenz* | 1 | MO |
| *efavirenz-emtricitabin-tenofov* | 4 | MO |
| *efavirenz-lamivu-tenofov disop* | 4 | MO |
| *emtricitabine* | 1 | MO |
| *emtricitabine-tenofovir (tdf)* | 4 | MO |
| EMTRIVA ORAL SOLUTION | 2 | MO |
| *entecavir* | 1 | MO |
| EPCLUSA ORAL TABLET 200-50 MG | 4 | PA; MO; QL (56 per 28 days) |
| EPCLUSA ORAL TABLET 400-100 MG | 4 | PA; MO; QL (28 per 28 days) |
| EPIVIR HBV ORAL SOLUTION | 3 | MO |
| EVOTAZ | 4 | MO |
| *famciclovir* | 1 | MO |
| *fosamprenavir* | 4 | MO |
| FUZEON SUBCUTANEOUS RECON SOLN | 4 | MO |
| GENVOYA | 4 | MO |
| HARVONI ORAL PELLETS IN PACKET 33.75-150 MG | 4 | PA; MO; QL (28 per 28 days) |
| HARVONI ORAL PELLETS IN PACKET 45-200 MG | 4 | PA; MO; QL (56 per 28 days) |
| HARVONI ORAL TABLET 45-200 MG | 4 | PA; MO; QL (56 per 28 days) |
| HARVONI ORAL TABLET 90-400 MG | 4 | PA; MO; QL (28 per 28 days) |
| INTELENCE ORAL TABLET 100 MG, 200 MG | 4 | MO |
| INTELENCE ORAL TABLET 25 MG | 3 | MO |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| INVIRASE ORAL TABLET | 4 | MO |
| ISENTRESS HD | 4 | MO |
| ISENTRESS ORAL POWDER IN PACKET | 4 | MO |
| ISENTRESS ORAL TABLET | 4 | MO |
| ISENTRESS ORAL TABLET,CHEWABLE 100 MG | 4 | MO |
| ISENTRESS ORAL TABLET,CHEWABLE 25 MG | 2 | MO |
| JULUCA | 4 | MO |
| KALETRA ORAL TABLET 100-25 MG | 3 | MO |
| KALETRA ORAL TABLET 200-50 MG | 4 | MO |
| *lamivudine* | 1 | MO |
| *lamivudine-zidovudine* | 1 | MO |
| LEXIVA ORAL SUSPENSION | 3 | MO |
| *lopinavir-ritonavir oral solution* | 1 | MO |
| *nevirapine oral suspension* | 1 | |
| *nevirapine oral tablet* | 1 | MO |
| *nevirapine oral tablet extended release 24 hr* | 1 | MO |
| NORVIR ORAL POWDER IN PACKET | 3 | MO |
| NORVIR ORAL SOLUTION | 3 | MO |
| ODEFSEY | 4 | MO |
| *oseltamivir* | 1 | MO |
| PIFELTRO | 4 | MO |
| PREVYMIS ORAL | 4 | MO; QL (30 per 30 days) |
| PREZCOBIX | 4 | MO |
| PREZISTA ORAL SUSPENSION | 4 | MO |
| PREZISTA ORAL TABLET 150 MG, 75 MG | 3 | MO |
| PREZISTA ORAL TABLET 600 MG, 800 MG | 4 | MO |
| RELENZA DISKHALER | 3 | MO |
| REYATAZ ORAL POWDER IN PACKET | 4 | MO |
| *ribavirin oral capsule* | 1 | |
| *ribavirin oral tablet 200 mg* | 1 | MO |
| *rimantadine* | 1 | MO |
| *ritonavir* | 1 | MO |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| RUKOBIA | 4 | MO |
| SELZENTRY ORAL SOLUTION | 2 | MO |
| SELZENTRY ORAL TABLET 150 MG, 300 MG | 4 | MO |
| SELZENTRY ORAL TABLET 25 MG, 75 MG | 2 | MO |
| STRIBILD | 4 | MO |
| SYMTUZA | 4 | MO |
| TEMIXYS | 4 | MO |
| *tenofovir disoproxil fumarate* | 1 | MO |
| TIVICAY ORAL TABLET 10 MG | 2 | MO |
| TIVICAY ORAL TABLET 25 MG, 50 MG | 4 | MO |
| TIVICAY PD | 4 | MO |
| TRIUMEQ | 4 | MO |
| *valacyclovir oral tablet 1 gram* | 1 | MO; QL (120 per 30 days) |
| *valacyclovir oral tablet 500 mg* | 1 | MO; QL (60 per 30 days) |
| *valganciclovir oral recon soln* | 4 | MO |
| *valganciclovir oral tablet* | 1 | MO |
| VEMLIDY | 4 | MO |
| VIRACEPT ORAL TABLET | 4 | MO |
| VIREAD ORAL POWDER | 4 | MO |
| VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG | 4 | MO |
| VOSEVI | 4 | PA; MO; QL (28 per 28 days) |
| XOFLUZA ORAL TABLET 20 MG, 40 MG | 2 | MO |
| *zidovudine* | 1 | MO |
| **CEPHALOSPORINS** | | |
| *cefaclor oral capsule* | 1 | MO |
| *cefaclor oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml* | 1 | MO |
| *cefaclor oral suspension for reconstitution 375 mg/5 ml* | 1 | |
| *cefaclor oral tablet extended release 12 hr* | 1 | MO |
| *cefadroxil oral capsule* | 1 | MO |

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at **express-scripts.com**.

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *cefadroxil oral suspension for reconstitution 250 mg/5 ml, 500 mg/5 ml* | 1 | MO |
| *cefadroxil oral tablet* | 1 | MO |
| *cefazolin injection recon soln 1 gram, 500 mg* | 1 | MO |
| *cefazolin injection recon soln 10 gram* | 1 | |
| *cefdinir* | 1 | MO |
| *cefepime injection* | 1 | MO |
| *cefixime* | 1 | MO |
| *cefoxitin intravenous recon soln 1 gram, 2 gram* | 1 | PA; MO |
| *cefoxitin intravenous recon soln 10 gram* | 1 | PA |
| *cefpodoxime* | 1 | MO |
| *cefprozil* | 1 | MO |
| *ceftazidime injection recon soln 1 gram, 2 gram* | 1 | PA; MO |
| *ceftazidime injection recon soln 6 gram* | 1 | PA |
| *ceftriaxone injection recon soln 1 gram, 2 gram, 250 mg, 500 mg* | 1 | MO |
| *ceftriaxone injection recon soln 10 gram* | 1 | |
| *cefuroxime axetil oral tablet* | 1 | MO |
| *cefuroxime sodium injection recon soln 750 mg* | 1 | PA; MO |
| *cefuroxime sodium intravenous recon soln 1.5 gram* | 1 | PA; MO |
| *cefuroxime sodium intravenous recon soln 7.5 gram* | 1 | PA |
| *cephalexin oral capsule 250 mg, 500 mg* | 1 | MO |
| *cephalexin oral suspension for reconstitution* | 1 | MO |
| SUPRAX ORAL SUSPENSION FOR RECONSTITUTION 500 MG/5 ML | 3 | |
| SUPRAX ORAL TABLET,CHEWABLE | 3 | MO |
| *tazicef injection recon soln 1 gram, 2 gram* | 1 | PA |
| *tazicef injection recon soln 6 gram* | 1 | PA; MO |
| TEFLARO | 4 | PA; MO |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **ERYTHROMYCINS / OTHER MACROLIDES** | | |
| *azithromycin intravenous* | 1 | PA; MO |
| *azithromycin oral packet* | 1 | MO |
| *azithromycin oral suspension for reconstitution* | 1 | MO |
| *azithromycin oral tablet 250 mg (6 pack), 500 mg (3 pack)* | 1 | |
| *azithromycin oral tablet 250 mg, 500 mg, 600 mg* | 1 | MO |
| *clarithromycin* | 1 | MO |
| *ery-tab oral tablet,delayed release (dr/ec) 250 mg, 333 mg* | 1 | MO |
| *erythrocin (as stearate) oral tablet 250 mg* | 1 | MO |
| ERYTHROCIN INTRAVENOUS RECON SOLN 500 MG | 3 | PA; MO |
| *erythromycin ethylsuccinate oral tablet* | 1 | |
| *erythromycin oral* | 1 | MO |

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **MISCELLANEOUS ANTIINFECTIVES** | | |
| *albendazole* | 4 | MO |
| *amikacin injection solution 500 mg/2 ml* | 1 | PA; MO |
| ARIKAYCE | 4 | PA; LA |
| *atovaquone* | 4 | MO |
| *atovaquone-proguanil* | 1 | MO |
| *aztreonam injection recon soln 1 gram* | 1 | PA; MO |
| BENZNIDAZOLE | 2 | MO |
| CAYSTON | 4 | PA; MO; LA; QL (84 per 28 days) |
| *chloroquine phosphate* | 1 | MO |
| *clindamycin hcl* | 1 | MO |
| *clindamycin in 5 % dextrose* | 1 | PA; MO |
| *clindamycin pediatric* | 1 | MO |
| *clindamycin phosphate injection* | 1 | PA; MO |
| *clindamycin phosphate intravenous solution 600 mg/4 ml* | 1 | PA; MO |
| COARTEM | 3 | MO |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *colistin (colistimethate na)* | 1 | PA; MO |
| *dapsone oral* | 1 | MO |
| DAPTOMYCIN INTRAVENOUS RECON SOLN 350 MG | 4 | MO |
| *daptomycin intravenous recon soln 500 mg* | 4 | MO |
| EMVERM | 4 | MO |
| *ertapenem* | 1 | PA; MO; QL (14 per 14 days) |
| *ethambutol* | 1 | MO |
| *gentamicin in nacl (iso-osm) intravenous piggyback 100 mg/100 ml, 60 mg/50 ml, 80 mg/50 ml* | 1 | PA; MO |
| *gentamicin in nacl (iso-osm) intravenous piggyback 80 mg/100 ml* | 1 | PA |
| *gentamicin injection solution 40 mg/ml* | 1 | PA; MO |
| *hydroxychloroquine* | 1 | MO |
| *imipenem-cilastatin* | 1 | PA; MO |
| IMPAVIDO | 4 | PA; MO |
| *isoniazid oral* | 1 | MO |
| *ivermectin oral* | 1 | MO |
| *linezolid in dextrose 5%* | 1 | PA |
| *linezolid oral suspension for reconstitution* | 4 | MO |
| *linezolid oral tablet* | 1 | MO |
| *mefloquine* | 1 | MO |
| *meropenem intravenous recon soln 1 gram* | 1 | PA; MO; QL (30 per 10 days) |
| *meropenem intravenous recon soln 500 mg* | 1 | PA; MO; QL (10 per 10 days) |
| *metronidazole in nacl (iso-os)* | 1 | PA; MO |
| *metronidazole oral tablet* | 1 | MO |
| *neomycin* | 1 | MO |
| *nitazoxanide* | 4 | MO |
| *paromomycin* | 1 | MO |
| PASER | 2 | MO |
| *pentamidine inhalation* | 1 | PA; MO; QL (1 per 28 days) |
| *pentamidine injection* | 1 | MO |
| *praziquantel* | 1 | MO |
| PRIFTIN | 2 | MO |
| PRIMAQUINE | 2 | MO |
| *pyrazinamide* | 1 | MO |
| *pyrimethamine* | 4 | PA; MO |
| *quinine sulfate* | 1 | MO |
| *rifabutin* | 1 | MO |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *rifampin* | 1 | MO |
| SIRTURO | 4 | PA; LA |
| STREPTOMYCIN | 2 | PA; MO |
| *tigecycline* | 4 | PA; MO |
| *tinidazole* | 1 | MO |
| TOBI PODHALER INHALATION CAPSULE, W/INHALATION DEVICE | 4 | MO; QL (224 per 28 days) |
| *tobramycin in 0.225 % nacl* | 4 | PA; MO; QL (280 per 28 days) |
| *tobramycin inhalation* | 4 | PA; MO; QL (224 per 28 days) |
| *tobramycin sulfate injection solution* | 1 | PA; MO |
| TRECATOR | 3 | MO |
| *vancomycin intravenous recon soln 1,000 mg, 750 mg* | 1 | PA; MO; QL (20 per 10 days) |
| *vancomycin intravenous recon soln 10 gram* | 1 | PA; QL (2 per 10 days) |
| *vancomycin intravenous recon soln 500 mg* | 1 | PA; MO; QL (10 per 10 days) |
| *vancomycin oral capsule 125 mg* | 1 | PA; MO; QL (40 per 10 days) |
| *vancomycin oral capsule 250 mg* | 1 | PA; MO; QL (80 per 10 days) |
| XIFAXAN ORAL TABLET 200 MG | 4 | PA; MO; QL (9 per 30 days) |
| XIFAXAN ORAL TABLET 550 MG | 4 | PA; MO; QL (90 per 30 days) |
| **PENICILLINS** | | |
| *amoxicillin oral capsule* | 1 | MO |
| *amoxicillin oral suspension for reconstitution* | 1 | MO |
| *amoxicillin oral tablet* | 1 | MO |
| *amoxicillin oral tablet,chewable 125 mg, 250 mg* | 1 | MO |
| *amoxicillin-pot clavulanate* | 1 | MO |
| *ampicillin oral capsule 500 mg* | 1 | MO |
| *ampicillin sodium injection recon soln 1 gram, 10 gram, 125 mg* | 1 | PA; MO |
| *ampicillin-sulbactam injection recon soln 1.5 gram, 3 gram* | 1 | PA; MO |

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|---|---|---|
| *ampicillin-sulbactam injection recon soln 15 gram* | 1 | PA |
| BICILLIN C-R | 2 | PA; MO |
| BICILLIN L-A | 3 | PA; MO |
| *dicloxacillin* | 1 | MO |
| *nafcillin injection recon soln 1 gram, 2 gram* | 1 | PA; MO |
| *nafcillin injection recon soln 10 gram* | 4 | PA |
| *oxacillin in dextrose(iso-osm) intravenous piggyback 1 gram/50 ml* | 1 | PA |
| *oxacillin in dextrose(iso-osm) intravenous piggyback 2 gram/50 ml* | 1 | PA; MO |
| *oxacillin injection recon soln 1 gram, 10 gram* | 1 | PA |
| *oxacillin injection recon soln 2 gram* | 1 | PA; MO |
| PENICILLIN G POT IN DEXTROSE INTRAVENOUS PIGGYBACK 2 MILLION UNIT/50 ML, 3 MILLION UNIT/50 ML | 3 | PA |
| *penicillin g potassium injection recon soln 20 million unit* | 1 | PA; MO |
| *penicillin g procaine intramuscular syringe 1.2 million unit/2 ml* | 1 | PA; MO |
| *penicillin g sodium* | 1 | PA; MO |
| *penicillin v potassium* | 1 | MO |
| *piperacillin-tazobactam intravenous recon soln 2.25 gram, 3.375 gram, 4.5 gram* | 1 | MO |
| *piperacillin-tazobactam intravenous recon soln 40.5 gram* | 1 | |
| **QUINOLONES** | | |
| *ciprofloxacin hcl oral* | 1 | MO |
| *ciprofloxacin in 5 % dextrose intravenous piggyback 200 mg/100 ml* | 1 | PA; MO |
| *levofloxacin in d5w intravenous piggyback 500 mg/100 ml, 750 mg/150 ml* | 1 | PA; MO |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *levofloxacin intravenous* | 1 | PA; MO |
| *levofloxacin oral* | 1 | MO |
| *moxifloxacin oral* | 1 | MO |
| *moxifloxacin-sod.chloride(iso)* | 1 | PA; MO |
| *ofloxacin oral tablet 300 mg, 400 mg* | 1 | MO |
| **SULFA'S / RELATED AGENTS** | | |
| *sulfadiazine* | 1 | MO |
| *sulfamethoxazole-trimethoprim oral* | 1 | MO |
| **TETRACYCLINES** | | |
| *demeclocycline* | 1 | MO |
| *doxy-100* | 1 | PA; MO |
| *doxycycline hyclate oral capsule* | 1 | MO |
| *doxycycline hyclate oral tablet 20 mg* | 1 | MO |
| *doxycycline monohydrate oral capsule 100 mg, 50 mg* | 1 | MO |
| *doxycycline monohydrate oral suspension for reconstitution* | 1 | MO |
| *doxycycline monohydrate oral tablet 100 mg, 50 mg, 75 mg* | 1 | MO |
| *minocycline oral capsule* | 1 | MO |
| *minocycline oral tablet* | 1 | MO |
| *mondoxyne nl oral capsule 100 mg* | 1 | MO |
| *tetracycline* | 1 | MO |
| VIBRAMYCIN ORAL SYRUP | 2 | MO |
| **URINARY TRACT AGENTS** | | |
| *methenamine hippurate* | 1 | MO |
| *nitrofurantoin* | 1 | MO |
| *nitrofurantoin macrocrystal oral capsule 100 mg, 50 mg* | 1 | MO |
| *nitrofurantoin monohydlm-cryst* | 1 | MO |
| *trimethoprim* | 1 | MO |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **ANTINEOPLASTIC / IMMUNOSUPPRESSANT DRUGS** | | |
| **ADJUNCTIVE AGENTS** | | |
| *leucovorin calcium oral* | 1 | MO |
| MESNEX ORAL | 4 | MO |
| XGEVA | 4 | PA; MO |
| **ANTINEOPLASTIC / IMMUNOSUPPRESSANT DRUGS** | | |
| *abiraterone oral tablet 250 mg* | 4 | PA; MO; QL (120 per 30 days) |
| *abiraterone oral tablet 500 mg* | 4 | PA; MO; QL (60 per 30 days) |
| AFINITOR DISPERZ | 4 | PA; MO |
| AFINITOR ORAL TABLET 10 MG | 4 | PA; MO; QL (30 per 30 days) |
| ALECENSA | 4 | PA; MO; QL (240 per 30 days) |
| ALUNBRIG ORAL TABLET 180 MG, 90 MG | 4 | PA; QL (30 per 30 days) |
| ALUNBRIG ORAL TABLET 30 MG | 4 | PA; QL (60 per 30 days) |
| ALUNBRIG ORAL TABLETS,DOSE PACK | 4 | PA; QL (30 per 30 days) |
| *anastrozole* | 1 | MO |
| AYVAKIT ORAL TABLET 100 MG, 200 MG, 300 MG | 4 | PA; LA; QL (30 per 30 days) |
| *azathioprine* | 1 | PA; MO |
| BALVERSA | 4 | PA; LA |
| *bexarotene* | 4 | PA; MO |
| *bicalutamide* | 1 | MO |
| BOSULIF ORAL TABLET 100 MG | 4 | PA; MO; QL (90 per 30 days) |
| BOSULIF ORAL TABLET 400 MG, 500 MG | 4 | PA; MO; QL (30 per 30 days) |
| BRAFTOVI ORAL CAPSULE 75 MG | 4 | PA; MO; LA; QL (180 per 30 days) |
| BRUKINSA | 4 | PA; LA |
| CABOMETYX | 4 | PA; MO; LA; QL (30 per 30 days) |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| CALQUENCE | 4 | PA; LA; QL (60 per 30 days) |
| CAPRELSA ORAL TABLET 100 MG | 4 | PA; LA; QL (60 per 30 days) |
| CAPRELSA ORAL TABLET 300 MG | 4 | PA; LA; QL (30 per 30 days) |
| COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1) | 4 | PA; MO; QL (56 per 28 days) |
| COMETRIQ ORAL CAPSULE 140 MG/DAY(80 MG X1-20 MG X3) | 4 | PA; MO; QL (112 per 28 days) |
| COMETRIQ ORAL CAPSULE 60 MG/DAY (20 MG X 3/DAY) | 4 | PA; MO; QL (84 per 28 days) |
| COPIKTRA | 4 | PA; LA; QL (60 per 30 days) |
| COTELLIC | 4 | PA; MO; LA; QL (63 per 28 days) |
| *cyclophosphamide oral capsule* | 1 | PA; MO |
| CYCLOPHOSPHAMIDE ORAL TABLET | 2 | PA; MO |
| *cyclosporine modified oral capsule* | 1 | PA; MO |
| *cyclosporine modified oral solution* | 1 | PA |
| *cyclosporine oral capsule* | 1 | PA; MO |
| DAURISMO ORAL TABLET 100 MG | 4 | PA; MO; QL (30 per 30 days) |
| DAURISMO ORAL TABLET 25 MG | 4 | PA; MO; QL (60 per 30 days) |
| DROXIA | 2 | MO |
| EMCYT | 4 | MO |
| ENVARSUS XR | 3 | PA; MO |
| ERIVEDGE | 4 | PA; MO; QL (30 per 30 days) |
| ERLEADA | 4 | PA; MO; QL (120 per 30 days) |
| *erlotinib oral tablet 100 mg, 150 mg* | 4 | PA; MO; QL (30 per 30 days) |
| *erlotinib oral tablet 25 mg* | 4 | PA; MO; QL (60 per 30 days) |
| *everolimus (antineoplastic)* | 4 | PA; MO; QL (30 per 30 days) |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *everolimus (immunosuppressive)* | 4 | PA; MO |
| *exemestane* | 1 | MO |
| FARYDAK | 4 | PA; MO; QL (6 per 21 days) |
| FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 120 MG | 4 | PA; MO |
| FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 80 MG | 3 | PA; MO |
| *flutamide* | 1 | MO |
| FOTIVDA | 4 | PA; LA; QL (21 per 28 days) |
| GAVRETO | 4 | PA; MO; LA; QL (120 per 30 days) |
| *gengraf* | 1 | PA; MO |
| GILOTRIF | 4 | PA; MO; QL (30 per 30 days) |
| *hydroxyurea* | 1 | MO |
| IBRANCE | 4 | PA; MO; QL (21 per 28 days) |
| ICLUSIG | 4 | PA; QL (30 per 30 days) |
| IDHIFA | 4 | PA; MO; LA; QL (30 per 30 days) |
| *imatinib oral tablet 100 mg* | 4 | PA; MO; QL (180 per 30 days) |
| *imatinib oral tablet 400 mg* | 4 | PA; MO; QL (60 per 30 days) |
| IMBRUVICA ORAL CAPSULE 140 MG | 4 | PA; QL (120 per 30 days) |
| IMBRUVICA ORAL CAPSULE 70 MG | 4 | PA; QL (30 per 30 days) |
| IMBRUVICA ORAL TABLET 280 MG, 420 MG, 560 MG | 4 | PA; QL (30 per 30 days) |
| INLYTA ORAL TABLET 1 MG | 4 | PA; MO; QL (180 per 30 days) |
| INLYTA ORAL TABLET 5 MG | 4 | PA; MO; QL (120 per 30 days) |
| INQOVI | 4 | PA; MO; QL (5 per 28 days) |
| INREBIC | 4 | PA; MO; LA; QL (120 per 30 days) |

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|---|---|---|
| IRESSA | 4 | PA; MO; QL (30 per 30 days) |
| JAKAFI | 4 | PA; MO; QL (60 per 30 days) |
| KISQALI FEMARA CO-PACK ORAL TABLET 200 MG/DAY(200 MG X 1)-2.5 MG | 4 | PA; MO; QL (49 per 28 days) |
| KISQALI FEMARA CO-PACK ORAL TABLET 400 MG/DAY(200 MG X 2)-2.5 MG | 4 | PA; MO; QL (70 per 28 days) |
| KISQALI FEMARA CO-PACK ORAL TABLET 600 MG/DAY(200 MG X 3)-2.5 MG | 4 | PA; MO; QL (91 per 28 days) |
| KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1) | 4 | PA; MO; QL (21 per 28 days) |
| KISQALI ORAL TABLET 400 MG/DAY (200 MG X 2) | 4 | PA; MO; QL (42 per 28 days) |
| KISQALI ORAL TABLET 600 MG/DAY (200 MG X 3) | 4 | PA; MO; QL (63 per 28 days) |
| *lapatinib* | 4 | PA; MO; QL (180 per 30 days) |
| LENVIMA | 4 | PA; MO |
| *letrozole* | 1 | MO |
| LEUKERAN | 4 | MO |
| *leuprolide subcutaneous kit* | 4 | PA; MO |
| LONSURF | 4 | PA; MO |
| LORBRENA ORAL TABLET 100 MG | 4 | PA; MO; QL (30 per 30 days) |
| LORBRENA ORAL TABLET 25 MG | 4 | PA; MO; QL (90 per 30 days) |
| LUPRON DEPOT | 4 | PA; MO |
| LUPRON DEPOT (3 MONTH) | 4 | PA; MO |
| LUPRON DEPOT (4 MONTH) | 4 | PA; MO |
| LUPRON DEPOT (6 MONTH) | 4 | PA; MO |
| LYNPARZA ORAL TABLET | 4 | PA; MO; QL (120 per 30 days) |
| LYSODREN | 2 | |
| MATULANE | 4 | |
| *megestrol oral suspension 400 mg/10 ml (40 mg/ml), 625 mg/5 ml (125 mg/ml)* | 1 | PA; MO |
| *megestrol oral tablet* | 1 | PA; MO |

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|---|---|---|
| MEKINIST ORAL TABLET 0.5 MG | 4 | PA; MO; QL (90 per 30 days) |
| MEKINIST ORAL TABLET 2 MG | 4 | PA; MO; QL (30 per 30 days) |
| MEKTOVI | 4 | PA; MO; LA; QL (180 per 30 days) |
| *mercaptopurine* | 1 | MO |
| *methotrexate sodium* | 1 | PA; MO |
| *methotrexate sodium (pf) injection solution* | 1 | PA; MO |
| MVASI | 4 | PA; MO |
| *mycophenolate mofetil oral capsule* | 1 | PA; MO |
| *mycophenolate mofetil oral suspension for reconstitution* | 4 | PA; MO |
| *mycophenolate mofetil oral tablet* | 1 | PA; MO |
| *mycophenolate sodium* | 1 | PA; MO |
| NERLYNX | 4 | PA; MO; LA |
| NEXAVAR | 4 | PA; MO; LA; QL (120 per 30 days) |
| *nilutamide* | 4 | PA; MO |
| NINLARO | 4 | PA; MO; QL (3 per 28 days) |
| NUBEQA | 4 | PA; MO; LA; QL (120 per 30 days) |
| *octreotide acetate injection solution 1,000 mcg/ml, 500 mcg/ml* | 4 | PA; MO |
| *octreotide acetate injection solution 100 mcg/ml, 200 mcg/ml, 50 mcg/ml* | 1 | PA; MO |
| ODOMZO | 4 | PA; MO; LA; QL (30 per 30 days) |
| ONUREG | 4 | PA; MO; QL (14 per 14 days) |
| ORGOVYX | 4 | PA; LA; QL (30 per 30 days) |
| PEMAZYRE | 4 | PA; LA; QL (14 per 21 days) |
| PIQRAY | 4 | PA; MO |
| POMALYST | 4 | PA; MO; LA |
| PROGRAF ORAL GRANULES IN PACKET | 3 | PA; MO |
| PURIXAN | 4 | |

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|---|---|---|
| QINLOCK | 4 | PA; LA; QL (90 per 30 days) |
| RETEVMO ORAL CAPSULE 40 MG | 4 | PA; MO; LA; QL (180 per 30 days) |
| RETEVMO ORAL CAPSULE 80 MG | 4 | PA; MO; LA; QL (120 per 30 days) |
| REVLIMID | 4 | PA; MO; LA; QL (28 per 28 days) |
| ROZLYTREK ORAL CAPSULE 100 MG | 4 | PA; MO; QL (150 per 30 days) |
| ROZLYTREK ORAL CAPSULE 200 MG | 4 | PA; MO; QL (90 per 30 days) |
| RUBRACA | 4 | PA; MO; LA; QL (120 per 30 days) |
| RUXIENCE | 4 | PA; MO |
| RYDAPT | 4 | PA; MO |
| SANDIMMUNE ORAL SOLUTION | 3 | PA; MO |
| SIGNIFOR | 4 | PA |
| *sirolimus oral solution* | 4 | PA; MO |
| *sirolimus oral tablet* | 1 | PA; MO |
| SOLTAMOX | 4 | MO |
| SPRYCEL ORAL TABLET 100 MG, 140 MG, 50 MG, 80 MG | 4 | PA; MO; QL (30 per 30 days) |
| SPRYCEL ORAL TABLET 20 MG, 70 MG | 4 | PA; MO; QL (60 per 30 days) |
| STIVARGA | 4 | PA; MO; QL (84 per 28 days) |
| SUTENT | 4 | PA; MO; QL (30 per 30 days) |
| SYNRIBO | 4 | PA |
| TABLOID | 3 | MO |
| TABRECTA | 4 | PA; MO |
| *tacrolimus oral* | 1 | PA; MO |
| TAFINLAR | 4 | PA; MO; QL (120 per 30 days) |
| TAGRISSO | 4 | PA; MO; LA; QL (30 per 30 days) |
| TALZENNA ORAL CAPSULE 0.25 MG | 4 | PA; MO; QL (90 per 30 days) |
| TALZENNA ORAL CAPSULE 1 MG | 4 | PA; MO; QL (30 per 30 days) |
| *tamoxifen* | 1 | MO |
| TARGRETIN TOPICAL | 4 | PA; MO |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| TASIGNA ORAL CAPSULE 150 MG, 200 MG | 4 | PA; MO; QL (112 per 28 days) |
| TASIGNA ORAL CAPSULE 50 MG | 4 | PA; MO; QL (120 per 30 days) |
| TAZVERIK | 4 | PA; LA |
| TEPMETKO | 4 | PA; LA |
| THALOMID | 4 | PA; MO |
| TIBSOVO | 4 | PA |
| *toremifene* | 4 | MO |
| TRAZIMERA | 4 | PA; MO |
| TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION | 4 | PA; MO |
| *tretinoin (antineoplastic)* | 4 | MO |
| TUKYSA ORAL TABLET 150 MG | 4 | PA; LA; QL (120 per 30 days) |
| TUKYSA ORAL TABLET 50 MG | 4 | PA; LA; QL (300 per 30 days) |
| TURALIO | 4 | PA; LA; QL (120 per 30 days) |
| UKONIQ | 4 | PA; LA; QL (120 per 30 days) |
| VENCLEXTA ORAL TABLET 10 MG | 2 | PA; LA; QL (60 per 30 days) |
| VENCLEXTA ORAL TABLET 100 MG | 4 | PA; LA; QL (120 per 30 days) |
| VENCLEXTA ORAL TABLET 50 MG | 4 | PA; LA; QL (30 per 30 days) |
| VENCLEXTA STARTING PACK | 4 | PA; LA; QL (42 per 30 days) |
| VERZENIO | 4 | PA; MO; LA; QL (60 per 30 days) |
| VITRAKVI ORAL CAPSULE 100 MG | 4 | PA; MO; LA; QL (60 per 30 days) |
| VITRAKVI ORAL CAPSULE 25 MG | 4 | PA; MO; LA; QL (180 per 30 days) |
| VITRAKVI ORAL SOLUTION | 4 | PA; MO; LA; QL (300 per 30 days) |
| VIZIMPRO | 4 | PA; MO; QL (30 per 30 days) |
| VOTRIENT | 4 | PA; MO; QL (120 per 30 days) |
| XALKORI | 4 | PA; MO; QL (60 per 30 days) |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| XATMEP | 3 | PA; MO |
| XERMELO | 4 | PA; LA; QL (90 per 30 days) |
| XOSPATA | 4 | PA; LA |
| XPOVIO | 4 | PA; LA |
| XTANDI ORAL CAPSULE | 4 | PA; MO; QL (120 per 30 days) |
| XTANDI ORAL TABLET 40 MG | 4 | PA; MO; QL (120 per 30 days) |
| XTANDI ORAL TABLET 80 MG | 4 | PA; MO; QL (60 per 30 days) |
| YONSA | 4 | PA; MO; QL (120 per 30 days) |
| ZEJULA | 4 | PA; LA; QL (90 per 30 days) |
| ZELBORAF | 4 | PA; MO; QL (240 per 30 days) |
| ZIRABEV | 4 | PA; MO |
| ZOLINZA | 4 | PA; MO |
| ZORTRESS ORAL TABLET 1 MG | 4 | PA; MO |
| ZYDELIG | 4 | PA; MO; QL (60 per 30 days) |
| ZYKADIA ORAL TABLET | 4 | PA; MO; QL (90 per 30 days) |
| **AUTONOMIC / CNS DRUGS, NEUROLOGY / PSYCH** | | |
| **ANTICONVULSANTS** | | |
| APTIOM ORAL TABLET 200 MG | 4 | MO; QL (180 per 30 days) |
| APTIOM ORAL TABLET 400 MG | 4 | MO; QL (90 per 30 days) |
| APTIOM ORAL TABLET 600 MG, 800 MG | 4 | MO; QL (60 per 30 days) |
| BRIVIACT INTRAVENOUS | 3 | QL (600 per 30 days) |
| BRIVIACT ORAL SOLUTION | 4 | MO; QL (600 per 30 days) |
| BRIVIACT ORAL TABLET | 4 | MO; QL (60 per 30 days) |
| *carbamazepine oral capsule, er multiphase 12 hr* | 1 | MO |
| *carbamazepine oral suspension 100 mg/5 ml* | 1 | MO |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *carbamazepine oral tablet* | 1 | MO |
| *carbamazepine oral tablet extended release 12 hr* | 1 | MO |
| *carbamazepine oral tablet,chewable* | 1 | MO |
| CELONTIN ORAL CAPSULE 300 MG | 3 | MO |
| *clobazam oral suspension* | 1 | PA; MO; QL (480 per 30 days) |
| *clobazam oral tablet* | 1 | PA; MO; QL (60 per 30 days) |
| *clonazepam oral tablet 0.5 mg, 1 mg* | 1 | MO; QL (90 per 30 days) |
| *clonazepam oral tablet 2 mg* | 1 | MO; QL (300 per 30 days) |
| *clonazepam oral tablet,disintegrating 0.125 mg, 0.25 mg, 0.5 mg, 1 mg* | 1 | MO; QL (90 per 30 days) |
| *clonazepam oral tablet,disintegrating 2 mg* | 1 | MO; QL (300 per 30 days) |
| DIACOMIT | 4 | PA; LA |
| *diazepam rectal* | 1 | MO |
| DILANTIN 30 MG | 2 | MO |

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *divalproex oral capsule, delayed rel sprinkle* | 1 | |
| *divalproex oral tablet extended release 24 hr* | 1 | MO |
| *divalproex oral tablet,delayed release (dr/ec)* | 1 | MO |
| EPIDIOLEX | 4 | PA; MO; LA |
| *epitol* | 1 | MO |
| *ethosuximide* | 1 | MO |
| *felbamate oral suspension* | 4 | MO |
| *felbamate oral tablet* | 1 | MO |
| FINTEPLA | 4 | PA; LA; QL (360 per 30 days) |
| FYCOMPA ORAL SUSPENSION | 4 | MO; QL (720 per 30 days) |
| FYCOMPA ORAL TABLET 10 MG, 12 MG, 8 MG | 4 | MO; QL (30 per 30 days) |
| FYCOMPA ORAL TABLET 2 MG | 3 | MO; QL (60 per 30 days) |
| FYCOMPA ORAL TABLET 4 MG, 6 MG | 4 | MO; QL (60 per 30 days) |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *gabapentin oral capsule 100 mg, 400 mg* | 1 | MO; QL (270 per 30 days) |
| *gabapentin oral capsule 300 mg* | 1 | MO; QL (360 per 30 days) |
| *gabapentin oral solution 250 mg/5 ml* | 1 | MO; QL (2160 per 30 days) |
| *gabapentin oral tablet 600 mg* | 1 | MO; QL (180 per 30 days) |
| *gabapentin oral tablet 800 mg* | 1 | MO; QL (120 per 30 days) |
| GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 300 MG | 2 | PA; MO; QL (30 per 30 days) |
| GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 600 MG | 2 | PA; MO; QL (90 per 30 days) |
| *lamotrigine oral tablet* | 1 | MO |
| *lamotrigine oral tablet disintegrating, dose pk 25 mg(14)-50 mg (14)-100 mg (7)* | 1 | MO |
| *lamotrigine oral tablet extended release 24hr* | 1 | MO |
| *lamotrigine oral tablet, chewable dispersible* | 1 | MO |
| *lamotrigine oral tablet,disintegrating* | 1 | MO |
| *lamotrigine oral tablets,dose pack* | 1 | MO |
| *levetiracetam oral solution 100 mg/ml* | 1 | MO |
| *levetiracetam oral tablet* | 1 | MO |
| *levetiracetam oral tablet extended release 24 hr* | 1 | MO |
| NAYZILAM | 4 | PA; MO; QL (10 per 30 days) |
| *oxcarbazepine* | 1 | MO |
| *phenobarbital oral elixir* | 1 | PA; MO |
| *phenobarbital oral tablet 100 mg, 15 mg, 30 mg, 60 mg* | 1 | PA |
| *phenobarbital oral tablet 16.2 mg, 32.4 mg, 64.8 mg, 97.2 mg* | 1 | PA; MO |
| *phenytoin oral suspension 125 mg/5 ml* | 1 | MO |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *phenytoin oral tablet,chewable* | 1 | MO |
| *phenytoin sodium extended* | 1 | MO |
| *pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg* | 1 | MO; QL (90 per 30 days) |
| *pregabalin oral capsule 225 mg, 300 mg* | 1 | MO; QL (60 per 30 days) |
| *pregabalin oral solution* | 1 | MO; QL (900 per 30 days) |
| *primidone* | 1 | MO |
| *roweepra oral tablet 500 mg* | 1 | MO |
| *rufinamide* | 4 | PA; MO |
| SPRITAM | 3 | MO |
| SYMPAZAN ORAL FILM 10 MG, 20 MG | 4 | PA; MO; QL (60 per 30 days) |
| SYMPAZAN ORAL FILM 5 MG | 3 | PA; MO; QL (60 per 30 days) |
| *tiagabine* | 1 | MO |
| *topiramate oral capsule, sprinkle* | 1 | PA; MO |
| *topiramate oral tablet* | 1 | PA; MO |
| *valproic acid* | 1 | MO |
| *valproic acid (as sodium salt) oral solution 250 mg/5 ml* | 1 | MO |
| VALTOCO | 4 | PA; MO; QL (10 per 30 days) |
| *vigabatrin* | 4 | MO; LA |
| *vigadrone* | 4 | LA |
| VIMPAT INTRAVENOUS | 2 | MO; QL (1200 per 30 days) |
| VIMPAT ORAL SOLUTION | 4 | MO; QL (1200 per 30 days) |
| VIMPAT ORAL TABLET 100 MG, 150 MG, 200 MG | 4 | MO; QL (60 per 30 days) |
| VIMPAT ORAL TABLET 50 MG | 2 | MO; QL (120 per 30 days) |
| XCOPRI MAINTENANCE PACK | 4 | MO; QL (56 per 28 days) |
| XCOPRI ORAL TABLET 100 MG | 3 | MO; QL (120 per 30 days) |
| XCOPRI ORAL TABLET 150 MG | 3 | MO; QL (60 per 30 days) |
| XCOPRI ORAL TABLET 200 MG | 4 | MO; QL (60 per 30 days) |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| XCOPRI ORAL TABLET 50 MG | 3 | MO; QL (240 per 30 days) |
| XCOPRI TITRATION PACK | 3 | MO; QL (56 per 28 days) |
| *zonisamide* | 1 | PA; MO |
| **ANTIPARKINSONISM AGENTS** | | |
| *benztropine oral* | 1 | PA; MO |
| *bromocriptine* | 1 | MO |
| *carbidopa* | 1 | MO |
| *carbidopa-levodopa* | 1 | MO |
| *carbidopa-levodopa-entacapone* | 1 | MO |
| *entacapone* | 1 | MO |
| KYNMOBI SUBLINGUAL FILM 10 MG, 15 MG, 20 MG, 25 MG, 30 MG | 4 | PA; MO; QL (150 per 30 days) |
| NEUPRO | 3 | MO |
| *pramipexole oral tablet* | 1 | MO |
| *rasagiline* | 1 | MO |
| *ropinirole* | 1 | MO |
| *selegiline hcl* | 1 | MO |

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **MIGRAINE / CLUSTER HEADACHE THERAPY** | | |
| AIMOVIG AUTOINJECTOR | 2 | PA; MO; QL (1 per 30 days) |
| AJOVY AUTOINJECTOR | 2 | PA; MO; QL (1.5 per 30 days) |
| AJOVY SYRINGE | 2 | PA; MO; QL (1.5 per 30 days) |
| *dihydroergotamine nasal* | 4 | QL (8 per 28 days) |
| *eletriptan* | 1 | MO; QL (18 per 28 days) |
| EMGALITY PEN | 2 | PA; MO; QL (2 per 30 days) |
| EMGALITY SUBCUTANEOUS SYRINGE 120 MG/ML | 2 | PA; MO; QL (2 per 30 days) |
| *ergotamine-caffeine* | 1 | MO |
| *naratriptan* | 1 | MO; QL (18 per 28 days) |
| NURTEC ODT | 2 | PA; QL (16 per 30 days) |
| *rizatriptan* | 1 | MO; QL (36 per 28 days) |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *sumatriptan nasal spray,non-aerosol 20 mg/actuation* | 1 | MO; QL (18 per 28 days) |
| *sumatriptan nasal spray,non-aerosol 5 mg/actuation* | 1 | MO; QL (36 per 28 days) |
| *sumatriptan succinate oral* | 1 | MO; QL (18 per 28 days) |
| *sumatriptan succinate subcutaneous cartridge* | 1 | MO; QL (8 per 28 days) |
| *sumatriptan succinate subcutaneous pen injector* | 1 | MO; QL (8 per 28 days) |
| *sumatriptan succinate subcutaneous solution* | 1 | MO; QL (8 per 28 days) |
| UBRELVY | 2 | PA; QL (20 per 30 days) |
| *zolmitriptan oral* | 1 | MO; QL (18 per 28 days) |
| **MISCELLANEOUS NEUROLOGICAL THERAPY** | | |
| AUBAGIO | 4 | PA; MO; QL (30 per 30 days) |
| BAFIERTAM | 4 | PA; MO; QL (120 per 30 days) |
| *dalfampridine* | 4 | PA; MO; QL (60 per 30 days) |
| *dimethyl fumarate oral capsule,delayed release(dr/ec) 120 mg* | 4 | PA; MO; QL (14 per 30 days) |
| *dimethyl fumarate oral capsule,delayed release(dr/ec) 120 mg (14)- 240 mg (46)* | 4 | PA; MO; QL (120 per 180 days) |
| *dimethyl fumarate oral capsule,delayed release(dr/ec) 240 mg* | 4 | PA; MO; QL (60 per 30 days) |
| *donepezil* | 1 | MO |
| FIRDAPSE | 4 | PA; LA |
| *galantamine* | 1 | MO |
| GILENYA ORAL CAPSULE 0.5 MG | 4 | PA; MO; QL (30 per 30 days) |
| *glatiramer subcutaneous syringe 20 mg/ml* | 4 | PA; QL (30 per 30 days) |
| *glatiramer subcutaneous syringe 40 mg/ml* | 4 | PA; QL (12 per 28 days) |
| *glatopa subcutaneous syringe 20 mg/ml* | 4 | PA; MO; QL (30 per 30 days) |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *glatopa subcutaneous syringe 40 mg/ml* | 4 | PA; MO; QL (12 per 28 days) |
| *memantine oral capsule,sprinkle,er 24hr* | 1 | PA; MO |
| *memantine oral solution* | 1 | PA; MO |
| *memantine oral tablet* | 1 | PA; MO |
| NAMZARIC | 2 | PA; MO |
| NUEDEXTA | 4 | PA; MO |
| *rivastigmine* | 1 | MO |
| *rivastigmine tartrate* | 1 | MO |
| *tetrabenazine oral tablet 12.5 mg* | 4 | PA; MO; QL (240 per 30 days) |
| *tetrabenazine oral tablet 25 mg* | 4 | PA; MO; QL (120 per 30 days) |
| VUMERITY | 4 | PA; MO; QL (120 per 30 days) |
| ZEPOSIA | 4 | PA; MO; QL (30 per 30 days) |
| ZEPOSIA STARTER KIT | 4 | PA; MO; QL (37 per 30 days) |
| ZEPOSIA STARTER PACK | 4 | PA; MO; QL (7 per 30 days) |

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **MUSCLE RELAXANTS / ANTISPASMODIC THERAPY** | | |
| *baclofen oral* | 1 | MO |
| *cyclobenzaprine oral tablet 10 mg, 5 mg* | 1 | PA; MO |
| *dantrolene oral* | 1 | MO |
| *pyridostigmine bromide oral tablet 60 mg* | 1 | MO |
| *pyridostigmine bromide oral tablet extended release* | 1 | MO |
| *tizanidine oral tablet* | 1 | MO |
| **NARCOTIC ANALGESICS** | | |
| *acetaminophen-caff-dihydrocod oral capsule* | 1 | MO; QL (300 per 30 days) |
| *acetaminophen-codeine oral solution 120-12 mg/5 ml* | 1 | MO; QL (4500 per 30 days) |
| *acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg* | 1 | MO; QL (360 per 30 days) |
| *acetaminophen-codeine oral tablet 300-60 mg* | 1 | MO; QL (180 per 30 days) |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| BELBUCA | 2 | PA; MO; QL (60 per 30 days) |
| *buprenorphine hcl sublingual* | 1 | MO |
| *buprenorphine transdermal patch* | 1 | PA; MO; QL (4 per 28 days) |
| *endocet oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg* | 1 | MO; QL (360 per 30 days) |
| *fentanyl citrate buccal lozenge on a handle 1,200 mcg, 1,600 mcg, 400 mcg, 600 mcg, 800 mcg* | 4 | PA; MO; QL (120 per 30 days) |
| *fentanyl citrate buccal lozenge on a handle 200 mcg* | 1 | PA; MO; QL (120 per 30 days) |
| *fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr* | 1 | PA; MO; QL (10 per 30 days) |
| *hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml* | 1 | MO; QL (5550 per 30 days) |
| *hydrocodone-acetaminophen oral tablet 10-300 mg, 5-300 mg, 7.5-300 mg* | 1 | MO; QL (390 per 30 days) |
| *hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg* | 1 | MO; QL (360 per 30 days) |
| *hydrocodone-ibuprofen* | 1 | MO; QL (50 per 30 days) |
| *hydromorphone (pf) injection solution 10 (mg/ml) (5 ml), 10 mg/ml* | 1 | QL (240 per 30 days) |
| *hydromorphone oral liquid* | 1 | MO; QL (2400 per 30 days) |
| *hydromorphone oral tablet* | 1 | MO; QL (180 per 30 days) |
| *hydromorphone oral tablet extended release 24 hr* | 1 | PA; MO; QL (60 per 30 days) |
| *methadone oral solution 10 mg/5 ml* | 1 | PA; MO; QL (600 per 30 days) |
| *methadone oral solution 5 mg/5 ml* | 1 | PA; MO; QL (1200 per 30 days) |
| *methadone oral tablet 10 mg* | 1 | PA; MO; QL (120 per 30 days) |
| *methadone oral tablet 5 mg* | 1 | PA; MO; QL (240 per 30 days) |
| *morphine concentrate oral solution* | 1 | MO; QL (900 per 30 days) |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *morphine oral solution* | 1 | MO; QL (900 per 30 days) |
| *morphine oral tablet* | 1 | MO; QL (180 per 30 days) |
| *morphine oral tablet extended release* | 1 | PA; MO; QL (120 per 30 days) |
| *oxycodone oral capsule* | 1 | MO; QL (360 per 30 days) |
| *oxycodone oral concentrate* | 1 | MO; QL (180 per 30 days) |
| *oxycodone oral solution* | 1 | MO; QL (1200 per 30 days) |
| *oxycodone oral tablet 10 mg, 15 mg, 20 mg, 30 mg* | 1 | MO; QL (180 per 30 days) |
| *oxycodone oral tablet 5 mg* | 1 | MO; QL (360 per 30 days) |
| *oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg* | 1 | MO; QL (360 per 30 days) |
| OXYCONTIN, ORAL ONLY, EXT.REL.12 HR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 60 MG | 2 | PA; MO; QL (90 per 30 days) |
| OXYCONTIN, ORAL ONLY, EXT.REL.12 HR 80 MG | 4 | PA; MO; QL (60 per 30 days) |
| **NON-NARCOTIC ANALGESICS** | | |
| *buprenorphine-naloxone sublingual film 12-3 mg* | 1 | MO; QL (60 per 30 days) |
| *buprenorphine-naloxone sublingual film 2-0.5 mg* | 1 | MO; QL (360 per 30 days) |
| *buprenorphine-naloxone sublingual film 4-1 mg, 8-2 mg* | 1 | MO; QL (90 per 30 days) |
| *buprenorphine-naloxone sublingual tablet 2-0.5 mg* | 1 | MO; QL (360 per 30 days) |
| *buprenorphine-naloxone sublingual tablet 8-2 mg* | 1 | MO; QL (90 per 30 days) |
| *butorphanol nasal* | 1 | MO; QL (10 per 28 days) |
| *celecoxib* | 1 | MO |
| *diclofenac potassium* | 1 | MO |
| *diclofenac sodium oral* | 1 | MO |
| *diclofenac sodium topical gel 1 %* | 1 | MO; QL (1000 per 28 days) |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *diclofenac-misoprostol* | 1 | MO |
| *diflunisal* | 1 | MO |
| *etodolac* | 1 | MO |
| *flurbiprofen oral tablet 100 mg* | 1 | MO |
| *ibu oral tablet 600 mg, 800 mg* | 1 | MO |
| *ibuprofen oral suspension* | 1 | MO |
| *ibuprofen oral tablet 400 mg, 600 mg, 800 mg* | 1 | MO |
| KLOXXADO | 2 | |
| *meloxicam oral tablet 15 mg* | 1 | MO |
| *meloxicam oral tablet 7.5 mg* | 1 | MO; QL (30 per 30 days) |
| *nabumetone* | 1 | MO |
| *naloxone injection solution* | 1 | MO |
| *naloxone injection syringe* | 1 | MO |
| *naltrexone* | 1 | MO |
| *naproxen oral suspension* | 1 | MO |
| *naproxen oral tablet* | 1 | MO |
| *naproxen oral tablet,delayed release (dr/ec) 375 mg* | 1 | MO |
| *naproxen oral tablet,delayed release (dr/ec) 500 mg* | 1 | |
| *naproxen sodium oral tablet 275 mg, 550 mg* | 1 | MO |
| NARCAN | 2 | MO |
| *oxaprozin* | 1 | MO |
| *piroxicam* | 1 | MO |
| *sulindac* | 1 | MO |
| *tramadol oral tablet 50 mg* | 1 | MO; QL (240 per 30 days) |
| *tramadol-acetaminophen* | 1 | MO; QL (240 per 30 days) |
| VIVITROL | 4 | MO |
| ZUBSOLV SUBLINGUAL TABLET 0.7-0.18 MG, 1.4-0.36 MG, 11.4-2.9 MG, 2.9-0.71 MG, 5.7-1.4 MG | 2 | MO; QL (30 per 30 days) |
| ZUBSOLV SUBLINGUAL TABLET 8.6-2.1 MG | 2 | MO; QL (60 per 30 days) |
| **PSYCHOTHERAPEUTIC DRUGS** | | |
| ABILIFY MAINTENA | 4 | MO; QL (1 per 28 days) |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *amitriptyline* | 1 | MO |
| *amoxapine* | 1 | MO |
| *aripiprazole oral solution* | 1 | MO |
| *aripiprazole oral tablet* | 1 | MO; QL (30 per 30 days) |
| *aripiprazole oral tablet,disintegrating* | 4 | MO; QL (60 per 30 days) |
| ARISTADA INITIO | 4 | MO; QL (4.8 per 365 days) |
| ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 1,064 MG/3.9 ML | 4 | MO; QL (3.9 per 56 days) |
| ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 441 MG/1.6 ML | 4 | MO; QL (1.6 per 28 days) |
| ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 662 MG/2.4 ML | 4 | MO; QL (2.4 per 28 days) |
| ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 882 MG/3.2 ML | 4 | MO; QL (3.2 per 28 days) |
| *armodafinil* | 1 | PA; MO; QL (30 per 30 days) |
| *asenapine maleate* | 1 | MO; QL (60 per 30 days) |
| *atomoxetine oral capsule 10 mg, 18 mg, 25 mg, 40 mg* | 1 | MO; QL (60 per 30 days) |
| *atomoxetine oral capsule 100 mg, 60 mg, 80 mg* | 1 | MO; QL (30 per 30 days) |
| *bupropion hcl oral tablet* | 1 | MO |
| *bupropion hcl oral tablet extended release 24 hr 150 mg* | 1 | MO; QL (90 per 30 days) |
| *bupropion hcl oral tablet extended release 24 hr 300 mg* | 1 | MO; QL (30 per 30 days) |
| *bupropion hcl oral tablet sustained-release 12 hr* | 1 | MO; QL (60 per 30 days) |
| *buspirone* | 1 | MO |
| CAPLYTA | 4 | MO; QL (30 per 30 days) |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *chlorpromazine oral tablet* | 1 | MO |
| *citalopram oral solution* | 1 | MO |
| *citalopram oral tablet* | 1 | MO; QL (30 per 30 days) |
| *clomipramine* | 1 | MO |
| *clonidine hcl oral tablet extended release 12 hr* | 1 | MO |
| *clorazepate dipotassium oral tablet 15 mg* | 1 | PA; MO; QL (180 per 30 days) |
| *clorazepate dipotassium oral tablet 3.75 mg* | 1 | PA; MO; QL (90 per 30 days) |
| *clorazepate dipotassium oral tablet 7.5 mg* | 1 | PA; MO; QL (360 per 30 days) |
| *clozapine* | 1 | |
| *desipramine* | 1 | MO |
| *desvenlafaxine succinate* | 1 | MO; QL (30 per 30 days) |
| *dextroamphetamine -amphetamine* | 1 | MO |
| *diazepam oral concentrate* | 1 | PA; MO; QL (240 per 30 days) |
| *diazepam oral solution 5 mg/5 ml (1 mg/ml)* | 1 | PA; MO; QL (1200 per 30 days) |
| *diazepam oral tablet* | 1 | PA; MO; QL (120 per 30 days) |
| *doxepin oral capsule* | 1 | MO |
| *doxepin oral concentrate* | 1 | MO |
| *doxepin oral tablet* | 1 | MO; QL (30 per 30 days) |
| DRIZALMA ORAL CAPSULE, DELAYED REL SPRINKLE 20 MG, 30 MG, 60 MG | 3 | MO; QL (60 per 30 days) |
| DRIZALMA ORAL CAPSULE, DELAYED REL SPRINKLE 40 MG | 3 | MO; QL (90 per 30 days) |
| *duloxetine oral capsule,delayed release(dr/ec) 20 mg, 30 mg, 60 mg* | 1 | MO; QL (60 per 30 days) |
| EMSAM | 4 | MO |
| *escitalopram oxalate oral solution* | 1 | MO |
| *escitalopram oxalate oral tablet* | 1 | MO; QL (30 per 30 days) |
| *eszopiclone* | 1 | MO; QL (30 per 30 days) |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| FANAPT ORAL TABLET 1 MG, 2 MG, 4 MG | 3 | MO; QL (60 per 30 days) |
| FANAPT ORAL TABLET 10 MG, 12 MG, 6 MG, 8 MG | 4 | MO; QL (60 per 30 days) |
| FANAPT ORAL TABLETS,DOSE PACK | 3 | MO; QL (8 per 28 days) |
| FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK | 2 | MO; QL (28 per 28 days) |
| FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR | 2 | MO; QL (30 per 30 days) |
| *fluoxetine (pmdd) oral tablet 10 mg* | 1 | QL (240 per 30 days) |
| *fluoxetine (pmdd) oral tablet 20 mg* | 1 | QL (120 per 30 days) |
| *fluoxetine oral capsule 10 mg, 20 mg* | 1 | MO; QL (30 per 30 days) |
| *fluoxetine oral capsule 40 mg* | 1 | MO; QL (60 per 30 days) |
| *fluoxetine oral capsule,delayed release(dr/ec)* | 1 | MO; QL (4 per 28 days) |
| *fluoxetine oral solution* | 1 | MO |
| *fluoxetine oral tablet 10 mg* | 1 | MO; QL (240 per 30 days) |
| *fluoxetine oral tablet 20 mg* | 1 | MO; QL (120 per 30 days) |
| *fluphenazine decanoate* | 1 | MO |
| *fluphenazine hcl* | 1 | MO |
| *fluvoxamine oral capsule,extended release 24hr* | 1 | MO; QL (60 per 30 days) |
| *fluvoxamine oral tablet 100 mg* | 1 | MO; QL (90 per 30 days) |
| *fluvoxamine oral tablet 25 mg* | 1 | MO; QL (30 per 30 days) |
| *fluvoxamine oral tablet 50 mg* | 1 | MO; QL (60 per 30 days) |
| FORFIVO XL | 3 | MO; QL (30 per 30 days) |
| *haloperidol* | 1 | MO |
| *haloperidol decanoate intramuscular solution 100 mg/ml, 100 mg/ml (1 ml), 50 mg/ml* | 1 | MO |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *haloperidol decanoate intramuscular solution 50 mg/ml(1ml)* | 1 | |
| *haloperidol lactate injection* | 1 | MO |
| *haloperidol lactate oral* | 1 | MO |
| HETLIOZ | 4 | PA; MO; QL (30 per 30 days) |
| *imipramine hcl* | 1 | MO |
| *imipramine pamoate* | 1 | MO |
| INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 117 MG/0.75 ML | 4 | MO; QL (0.75 per 28 days) |
| INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 156 MG/ML | 4 | MO; QL (1 per 28 days) |
| INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 234 MG/1.5 ML | 4 | MO; QL (1.5 per 28 days) |
| INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 39 MG/0.25 ML | 2 | MO; QL (0.25 per 28 days) |
| INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 78 MG/0.5 ML | 4 | MO; QL (0.5 per 28 days) |
| INVEGA TRINZA INTRAMUSCULAR SYRINGE 273 MG/0.875 ML | 4 | MO; QL (0.88 per 90 days) |
| INVEGA TRINZA INTRAMUSCULAR SYRINGE 410 MG/1.315 ML | 4 | MO; QL (1.32 per 90 days) |
| INVEGA TRINZA INTRAMUSCULAR SYRINGE 546 MG/1.75 ML | 4 | MO; QL (1.75 per 90 days) |
| INVEGA TRINZA INTRAMUSCULAR SYRINGE 819 MG/2.625 ML | 4 | MO; QL (2.63 per 90 days) |
| LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG | 4 | MO; QL (30 per 30 days) |
| LATUDA ORAL TABLET 80 MG | 4 | MO; QL (60 per 30 days) |
| *lithium carbonate* | 1 | MO |
| *lithium citrate oral solution 8 meq/5 ml* | 1 | MO |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *lorazepam intensol* | 1 | PA; QL (150 per 30 days) |
| *lorazepam oral tablet 0.5 mg, 1 mg* | 1 | PA; MO; QL (90 per 30 days) |
| *lorazepam oral tablet 2 mg* | 1 | PA; MO; QL (150 per 30 days) |
| *loxapine succinate* | 1 | MO |
| MARPLAN | 3 | MO |
| *methylphenidate hcl oral capsule,er biphasic 50-50* | 1 | MO |
| *methylphenidate hcl oral solution* | 1 | MO |
| *methylphenidate hcl oral tablet* | 1 | MO |
| *methylphenidate hcl oral tablet extended release* | 1 | MO |
| *methylphenidate hcl oral tablet,chewable* | 1 | MO |
| *mirtazapine* | 1 | MO |
| *modafinil oral tablet 100 mg* | 1 | PA; MO; QL (30 per 30 days) |
| *modafinil oral tablet 200 mg* | 1 | PA; MO; QL (60 per 30 days) |
| *molindone* | 1 | MO |
| *nefazodone* | 1 | MO |
| *nortriptyline* | 1 | MO |
| NUPLAZID ORAL CAPSULE | 4 | PA; MO; QL (30 per 30 days) |
| NUPLAZID ORAL TABLET 10 MG | 4 | PA; MO; QL (30 per 30 days) |
| *olanzapine intramuscular* | 1 | MO |
| *olanzapine oral* | 1 | MO; QL (30 per 30 days) |
| *olanzapine-fluoxetine* | 1 | MO |
| *paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg, 9 mg* | 1 | MO; QL (30 per 30 days) |
| *paliperidone oral tablet extended release 24hr 6 mg* | 1 | MO; QL (60 per 30 days) |
| *paroxetine hcl oral tablet 10 mg, 20 mg, 40 mg* | 1 | MO; QL (30 per 30 days) |
| *paroxetine hcl oral tablet 30 mg* | 1 | MO; QL (60 per 30 days) |
| *paroxetine hcl oral tablet extended release 24 hr* | 1 | MO; QL (60 per 30 days) |
| PAXIL ORAL SUSPENSION | 3 | MO |
| *perphenazine* | 1 | MO |
| PERSERIS | 4 | MO; QL (1 per 30 days) |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *phenelzine* | 1 | MO |
| *pimozide* | 1 | MO |
| *protriptyline* | 1 | MO |
| *quetiapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg* | 1 | MO; QL (90 per 30 days) |
| *quetiapine oral tablet 300 mg, 400 mg* | 1 | MO; QL (60 per 30 days) |
| *quetiapine oral tablet extended release 24 hr 150 mg, 200 mg* | 1 | MO; QL (30 per 30 days) |
| *quetiapine oral tablet extended release 24 hr 300 mg, 400 mg, 50 mg* | 1 | MO; QL (60 per 30 days) |
| *ramelteon* | 1 | MO; QL (30 per 30 days) |
| REXULTI | 4 | MO; QL (30 per 30 days) |
| RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 12.5 MG/2 ML, 25 MG/2 ML | 2 | MO; QL (2 per 28 days) |
| RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 37.5 MG/2 ML, 50 MG/2 ML | 4 | MO; QL (2 per 28 days) |
| *risperidone oral solution* | 1 | MO |
| *risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg* | 1 | MO; QL (60 per 30 days) |
| *risperidone oral tablet 4 mg* | 1 | MO; QL (120 per 30 days) |
| *risperidone oral tablet,disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg* | 1 | MO; QL (60 per 30 days) |
| *risperidone oral tablet,disintegrating 4 mg* | 1 | MO; QL (120 per 30 days) |
| SECUADO | 4 | MO; QL (30 per 30 days) |
| *sertraline oral concentrate* | 1 | MO |
| *sertraline oral tablet 100 mg, 50 mg* | 1 | MO; QL (60 per 30 days) |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *sertraline oral tablet 25 mg* | 1 | MO; QL (30 per 30 days) |
| *thioridazine* | 1 | MO |
| *thiothixene* | 1 | MO |
| *tranylcypromine* | 1 | MO |
| *trazodone* | 1 | MO |
| *trifluoperazine* | 1 | MO |
| *trimipramine* | 1 | MO |
| TRINTELLIX | 2 | MO; QL (30 per 30 days) |
| *venlafaxine oral capsule,extended release 24hr 150 mg, 37.5 mg* | 1 | MO; QL (30 per 30 days) |
| *venlafaxine oral capsule,extended release 24hr 75 mg* | 1 | MO; QL (90 per 30 days) |
| *venlafaxine oral tablet* | 1 | MO; QL (90 per 30 days) |
| *venlafaxine oral tablet extended release 24hr* | 1 | MO; QL (30 per 30 days) |
| VERSACLOZ | 4 | |
| VIIBRYD ORAL TABLET | 2 | MO; QL (30 per 30 days) |
| VIIBRYD ORAL TABLETS,DOSE PACK 10 MG (7)-20 MG (23) | 2 | MO; QL (30 per 30 days) |
| VRAYLAR ORAL CAPSULE | 4 | MO; QL (30 per 30 days) |
| VRAYLAR ORAL CAPSULE,DOSE PACK | 3 | MO; QL (7 per 30 days) |
| XYREM | 4 | PA; LA; QL (540 per 30 days) |
| *zaleplon oral capsule 10 mg* | 1 | MO; QL (60 per 30 days) |
| *zaleplon oral capsule 5 mg* | 1 | MO; QL (30 per 30 days) |
| *ziprasidone hcl* | 1 | MO; QL (60 per 30 days) |
| *ziprasidone mesylate* | 1 | |
| *zolpidem oral tablet* | 1 | MO; QL (30 per 30 days) |
| ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG | 2 | MO; QL (2 per 28 days) |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **CARDIOVASCULAR, HYPERTENSION / LIPIDS** | | |
| **ANTIARRHYTHMIC AGENTS** | | |
| *amiodarone oral tablet 100 mg, 400 mg* | 1 | |
| *amiodarone oral tablet 200 mg* | 1 | MO |
| *dofetilide* | 1 | MO |
| *flecainide* | 1 | MO |
| *mexiletine* | 1 | MO |
| *pacerone oral tablet 100 mg, 200 mg, 400 mg* | 1 | MO |
| *propafenone* | 1 | MO |
| *quinidine sulfate oral tablet* | 1 | MO |
| *sorine oral tablet 120 mg, 160 mg, 80 mg* | 1 | MO |
| *sorine oral tablet 240 mg* | 1 | |
| *sotalol af* | 1 | |
| *sotalol oral* | 1 | MO |
| **ANTIHYPERTENSIVE THERAPY** | | |
| *acebutolol* | 1 | MO |
| *aliskiren* | 1 | MO |
| *amiloride* | 1 | MO |
| *amiloride-hydrochlorothiazide* | 1 | MO |
| *amlodipine* | 1 | MO |
| *amlodipine-benazepril* | 1 | MO |
| *amlodipine-olmesartan* | 1 | MO |
| *amlodipine-valsartan* | 1 | MO |
| *amlodipine-valsartan-hcthiazid* | 1 | MO |
| *atenolol* | 1 | MO |
| *atenolol-chlorthalidone* | 1 | MO |
| *benazepril* | 1 | MO |
| *benazepril-hydrochlorothiazide* | 1 | MO |
| *betaxolol oral* | 1 | MO |
| BIDIL | 2 | MO; QL (180 per 30 days) |
| *bisoprolol fumarate* | 1 | MO |
| *bisoprolol-hydrochlorothiazide* | 1 | MO |
| *bumetanide* | 1 | MO |
| BYSTOLIC | 2 | MO |
| *candesartan* | 1 | MO |
| *candesartan-hydrochlorothiazid* | 1 | MO |
| *captopril* | 1 | MO |
| *cartia xt* | 1 | MO |

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|---|---|---|
| *carvedilol* | 1 | MO |
| *chlorthalidone oral tablet 25 mg, 50 mg* | 1 | MO |
| *clonidine* | 1 | MO; QL (4 per 28 days) |
| *clonidine hcl oral tablet* | 1 | MO |
| *diltiazem hcl oral capsule,extended release 12 hr* | 1 | MO |
| *diltiazem hcl oral capsule,extended release 24 hr 360 mg, 420 mg* | 1 | MO |
| *diltiazem hcl oral capsule,extended release 24hr 120 mg, 180 mg, 240 mg, 300 mg* | 1 | |
| *diltiazem hcl oral tablet* | 1 | MO |
| *diltiazem hcl oral tablet extended release 24 hr 180 mg, 240 mg, 300 mg, 360 mg* | 1 | |
| *dilt-xr* | 1 | MO |
| *doxazosin oral tablet 1 mg, 2 mg, 4 mg* | 1 | MO; QL (30 per 30 days) |
| *doxazosin oral tablet 8 mg* | 1 | MO; QL (60 per 30 days) |
| EDARBI | 2 | MO |
| EDARBYCLOR | 2 | MO |
| *enalapril maleate* | 1 | MO |
| *enalapril-hydrochlorothiazide* | 1 | MO |
| *eplerenone* | 1 | MO |
| *ethacrynic acid* | 1 | MO |
| *felodipine* | 1 | MO |
| *fosinopril* | 1 | MO |
| *fosinopril-hydrochlorothiazide* | 1 | MO |
| *furosemide injection* | 1 | MO |
| *furosemide oral solution 10 mg/ml, 40 mg/5 ml (8 mg/ml)* | 1 | MO |
| *furosemide oral tablet* | 1 | MO |
| *hydralazine oral* | 1 | MO |
| *hydrochlorothiazide* | 1 | MO |
| *indapamide* | 1 | MO |
| *irbesartan* | 1 | MO |
| *irbesartan-hydrochlorothiazide* | 1 | MO |
| *isradipine* | 1 | MO |
| *labetalol oral* | 1 | MO |
| *lisinopril* | 1 | MO |
| *lisinopril-hydrochlorothiazide* | 1 | MO |
| *losartan* | 1 | MO |
| *losartan-hydrochlorothiazide* | 1 | MO |
| *matzim la* | 1 | MO |

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|---|---|---|
| *methyldopa* | 1 | MO |
| *metolazone* | 1 | MO |
| *metoprolol succinate* | 1 | MO |
| *metoprolol ta-hydrochlorothiaz* | 1 | MO |
| *metoprolol tartrate oral* | 1 | MO |
| *metyrosine* | 4 | PA; MO |
| *minoxidil oral* | 1 | MO |
| *moexipril* | 1 | MO |
| *nadolol* | 1 | MO |
| *nicardipine oral* | 1 | MO |
| *nifedipine oral tablet extended release* | 1 | MO |
| *nifedipine oral tablet extended release 24hr* | 1 | MO |
| *nimodipine* | 1 | MO |
| *nisoldipine* | 1 | MO |
| *olmesartan* | 1 | MO |
| *olmesartan-amlodipin-hcthiazid* | 1 | MO |
| *olmesartan-hydrochlorothiazide* | 1 | MO |
| *perindopril erbumine* | 1 | MO |
| *pindolol* | 1 | MO |
| *prazosin* | 1 | MO |
| *propranolol oral* | 1 | MO |
| *quinapril* | 1 | MO |
| *quinapril-hydrochlorothiazide* | 1 | MO |
| *ramipril* | 1 | MO |
| *spironolactone* | 1 | MO |
| *spironolacton-hydrochlorothiaz* | 1 | MO |
| *taztia xt* | 1 | MO |
| TEKTURNA HCT | 2 | MO |
| *telmisartan* | 1 | MO |
| *telmisartan-amlodipine* | 1 | MO |
| *telmisartan-hydrochlorothiazid* | 1 | MO |
| *terazosin oral capsule 1 mg, 2 mg, 5 mg* | 1 | MO; QL (30 per 30 days) |
| *terazosin oral capsule 10 mg* | 1 | MO; QL (60 per 30 days) |
| *tiadylt er* | 1 | MO |
| *timolol maleate oral* | 1 | MO |
| *torsemide oral* | 1 | MO |
| *trandolapril* | 1 | MO |
| *trandolapril-verapamil* | 1 | MO |
| *treprostinil sodium* | 4 | PA; MO; LA |
| *triamterene-hydrochlorothiazid oral capsule 37.5-25 mg* | 1 | MO |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *triamterene-hydrochlorothiazid oral tablet* | 1 | MO |
| UPTRAVI | 4 | PA; MO; LA |
| *valsartan* | 1 | MO |
| *valsartan-hydrochlorothiazide* | 1 | MO |
| *verapamil oral* | 1 | MO |
| **COAGULATION THERAPY** | | |
| *aspirin-dipyridamole* | 1 | MO |
| BRILINTA | 2 | MO |
| CABLIVI INJECTION KIT | 4 | PA; LA |
| *cilostazol* | 1 | MO |
| *clopidogrel oral tablet 75 mg* | 1 | MO; QL (30 per 30 days) |
| *dipyridamole oral* | 1 | MO |
| DOPTELET (10 TAB PACK) | 4 | PA; MO; LA |
| DOPTELET (15 TAB PACK) | 4 | PA; MO; LA |
| DOPTELET (30 TAB PACK) | 4 | PA; MO; LA |
| ELIQUIS | 2 | MO |
| ELIQUIS DVT-PE TREAT 30D START | 2 | MO |
| *enoxaparin subcutaneous syringe 100 mg/ml, 150 mg/ml* | 1 | MO; QL (28 per 28 days) |
| *enoxaparin subcutaneous syringe 120 mg/0.8 ml, 80 mg/0.8 ml* | 1 | MO; QL (22.4 per 28 days) |
| *enoxaparin subcutaneous syringe 30 mg/0.3 ml, 60 mg/0.6 ml* | 1 | MO; QL (16.8 per 28 days) |
| *enoxaparin subcutaneous syringe 40 mg/0.4 ml* | 1 | MO; QL (11.2 per 28 days) |
| *fondaparinux subcutaneous syringe 10 mg/0.8 ml, 5 mg/0.4 ml, 7.5 mg/0.6 ml* | 4 | MO |
| *fondaparinux subcutaneous syringe 2.5 mg/0.5 ml* | 1 | MO |
| *heparin (porcine) injection solution* | 1 | MO |
| *jantoven* | 1 | MO |
| MULPLETA | 4 | PA; MO |
| *pentoxifylline* | 1 | MO |
| *prasugrel* | 1 | MO |
| PROMACTA | 4 | PA; MO; LA |
| *warfarin* | 1 | MO |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| XARELTO | 2 | MO |
| XARELTO DVT-PE TREAT 30D START | 2 | MO |
| **LIPID/CHOLESTEROL LOWERING AGENTS** | | |
| *amlodipine-atorvastatin* | 1 | MO; QL (30 per 30 days) |
| *atorvastatin* | 1 | MO; QL (30 per 30 days) |
| *cholestyramine (with sugar) oral powder in packet* | 1 | MO |
| *cholestyramine light oral powder in packet* | 1 | |
| *colesevelam* | 1 | MO |
| *colestipol oral packet* | 1 | MO |
| *colestipol oral tablet* | 1 | MO |
| *ezetimibe* | 1 | MO |
| *ezetimibe-simvastatin* | 1 | MO; QL (30 per 30 days) |
| *fenofibrate micronized oral capsule 134 mg, 200 mg, 43 mg, 67 mg* | 1 | MO |
| *fenofibrate nanocrystallized oral tablet 145 mg, 48 mg* | 1 | MO |
| *fenofibrate oral tablet 160 mg, 54 mg* | 1 | MO |
| *fenofibric acid (choline)* | 1 | MO |
| *fluvastatin oral capsule 20 mg* | 1 | MO; QL (30 per 30 days) |
| *fluvastatin oral capsule 40 mg* | 1 | MO; QL (60 per 30 days) |
| *gemfibrozil* | 1 | MO |
| *icosapent ethyl* | 1 | MO |
| JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 30 MG, 5 MG | 4 | PA; MO; LA |
| LIVALO | 2 | MO; QL (30 per 30 days) |
| *lovastatin oral tablet 10 mg* | 1 | MO; QL (30 per 30 days) |
| *lovastatin oral tablet 20 mg, 40 mg* | 1 | MO; QL (60 per 30 days) |
| NEXLETOL | 2 | PA; MO |
| NEXLIZET | 2 | PA; MO |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *niacin oral tablet extended release 24 hr* | 1 | |
| *omega-3 acid ethyl esters* | 1 | MO |
| *pravastatin* | 1 | MO; QL (30 per 30 days) |
| *prevalite oral powder in packet* | 1 | MO |
| REPATHA | 2 | PA; QL (3 per 28 days) |
| REPATHA PUSHTRONEX | 2 | PA; QL (3.5 per 28 days) |
| REPATHA SURECLICK | 2 | PA; QL (3 per 28 days) |
| *rosuvastatin* | 1 | MO; QL (30 per 30 days) |
| *simvastatin oral tablet* | 1 | MO; QL (30 per 30 days) |
| VASCEPA ORAL CAPSULE 0.5 GRAM | 2 | ST; MO |
| **MISCELLANEOUS CARDIOVASCULAR AGENTS** | | |
| CORLANOR ORAL SOLUTION | 2 | QL (450 per 30 days) |
| CORLANOR ORAL TABLET | 2 | MO; QL (60 per 30 days) |
| *digitek* | 1 | MO |
| *digox* | 1 | MO |
| *digoxin oral* | 1 | MO |
| ENTRESTO | 2 | MO; QL (60 per 30 days) |
| LANOXIN ORAL TABLET 62.5 MCG (0.0625 MG) | 2 | MO |
| *ranolazine* | 1 | MO |
| VECAMYL | 4 | |
| VERQUVO | 2 | MO; QL (30 per 30 days) |
| VYNDAMAX | 4 | PA; MO |
| VYNDAQEL | 4 | PA; MO |
| **NITRATES** | | |
| *isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg* | 1 | MO |
| *isosorbide mononitrate* | 1 | MO |
| *nitro-bid* | 1 | MO |
| *nitroglycerin sublingual* | 1 | MO |
| *nitroglycerin transdermal patch 24 hour* | 1 | MO |
| *nitroglycerin translingual* | 1 | MO |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **DERMATOLOGICALS/TOPICAL THERAPY** | | |
| **ANTIPSORIATIC / ANTISEBORRHEIC** | | |
| *acitretin* | 1 | MO |
| *calcipotriene scalp* | 1 | MO; QL (120 per 30 days) |
| *calcipotriene topical cream* | 1 | MO; QL (120 per 30 days) |
| *calcipotriene topical ointment* | 1 | MO; QL (120 per 30 days) |
| *calcipotriene-betamethasone* | 1 | MO; QL (400 per 30 days) |
| *calcitriol topical* | 1 | |
| *selenium sulfide topical lotion* | 1 | MO |
| SKYRIZI SUBCUTANEOUS PEN INJECTOR | 4 | PA; QL (2 per 28 days) |
| SKYRIZI SUBCUTANEOUS SYRINGE 150 MG/ML | 4 | PA; QL (2 per 28 days) |
| SKYRIZI SUBCUTANEOUS SYRINGE KIT | 4 | PA; MO; QL (1 per 28 days) |
| STELARA INTRAVENOUS | 4 | PA; MO; QL (104 per 28 days) |
| STELARA SUBCUTANEOUS SOLUTION | 4 | PA; MO; QL (0.5 per 28 days) |
| STELARA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML | 4 | PA; MO; QL (0.5 per 28 days) |
| STELARA SUBCUTANEOUS SYRINGE 90 MG/ML | 4 | PA; MO; QL (1 per 28 days) |
| TALTZ AUTOINJECTOR | 4 | PA; MO; QL (1 per 28 days) |
| TALTZ SYRINGE | 4 | PA; MO; QL (1 per 28 days) |
| **MISCELLANEOUS DERMATOLOGICALS** | | |
| *ammonium lactate* | 1 | MO |
| *diclofenac sodium topical gel 3 %* | 1 | PA; MO; QL (100 per 28 days) |
| DUPIXENT SUBCUTANEOUS PEN INJECTOR 300 MG/2 ML | 4 | PA; MO; QL (8 per 28 days) |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| DUPIXENT SUBCUTANEOUS SYRINGE 200 MG/1.14 ML | 4 | PA; MO; QL (4.56 per 28 days) |
| DUPIXENT SUBCUTANEOUS SYRINGE 300 MG/2 ML | 4 | PA; MO; QL (8 per 28 days) |
| *fluorouracil topical cream 5 %* | 1 | MO |
| *fluorouracil topical solution* | 1 | MO |
| *imiquimod topical cream in packet 5 %* | 1 | MO |
| *lidocaine hcl mucous membrane solution 4 % (40 mg/ml)* | 1 | MO |
| *lidocaine topical adhesive patch,medicated 5 %* | 1 | PA; MO; QL (90 per 30 days) |
| *lidocaine topical ointment* | 1 | MO; QL (36 per 30 days) |
| *lidocaine viscous* | 1 | MO |
| *lidocaine-prilocaine topical cream* | 1 | MO; QL (30 per 30 days) |
| *methoxsalen* | 4 | MO |
| *pimecrolimus* | 1 | PA; MO; QL (100 per 30 days) |
| *podofilox* | 1 | MO |
| REGRANEX | 4 | MO |
| SANTYL | 2 | MO |
| *silver sulfadiazine* | 1 | MO |
| *ssd* | 1 | MO |
| *tacrolimus topical* | 1 | PA; MO; QL (100 per 30 days) |
| VALCHLOR | 4 | PA; MO |
| **THERAPY FOR ACNE** | | |
| *accutane oral capsule 20 mg, 30 mg, 40 mg* | 1 | |
| *amnesteem* | 1 | |
| *avita topical cream* | 1 | PA; MO |
| *azelaic acid* | 1 | MO |
| *claravis* | 1 | |
| *clindamycin phosphate topical gel* | 1 | MO; QL (120 per 30 days) |
| *clindamycin phosphate topical lotion* | 1 | MO; QL (120 per 30 days) |
| *clindamycin phosphate topical solution* | 1 | MO; QL (120 per 30 days) |
| *ery pads* | 1 | MO |
| *erythromycin with ethanol topical solution* | 1 | MO |
| *isotretinoin* | 1 | |
| *metronidazole topical cream* | 1 | MO |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *metronidazole topical gel* | 1 | MO |
| *metronidazole topical lotion* | 1 | MO |
| *myorisan* | 1 | |
| *tazarotene topical cream* | 1 | PA; MO |
| TAZORAC TOPICAL CREAM 0.05 % | 3 | PA; MO |
| TAZORAC TOPICAL GEL | 3 | PA; MO |
| *tretinoin topical* | 1 | PA; MO |
| *zenatane* | 1 | |
| **TOPICAL ANTIBACTERIALS** | | |
| *gentamicin topical* | 1 | MO; QL (60 per 30 days) |
| *mafenide acetate* | 1 | MO |
| *mupirocin* | 1 | MO; QL (44 per 30 days) |
| *sulfacetamide sodium (acne)* | 1 | MO |
| SULFAMYLON TOPICAL CREAM | 2 | MO |

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **TOPICAL ANTIFUNGALS** | | |
| *ciclopirox topical cream* | 1 | MO; QL (90 per 28 days) |
| *ciclopirox topical gel* | 1 | MO; QL (45 per 28 days) |
| *ciclopirox topical shampoo* | 1 | MO; QL (120 per 28 days) |
| *ciclopirox topical solution* | 1 | MO |
| *ciclopirox topical suspension* | 1 | MO; QL (60 per 28 days) |
| *clotrimazole topical cream* | 1 | MO; QL (45 per 28 days) |
| *clotrimazole topical solution* | 1 | MO; QL (30 per 28 days) |
| *clotrimazole-betamethasone topical cream* | 1 | MO; QL (45 per 28 days) |
| *clotrimazole-betamethasone topical lotion* | 1 | MO; QL (60 per 28 days) |
| *econazole* | 1 | MO; QL (85 per 28 days) |
| *ketoconazole topical cream* | 1 | MO; QL (60 per 28 days) |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *ketoconazole topical shampoo* | 1 | MO; QL (120 per 28 days) |
| *naftifine topical cream* | 1 | MO; QL (60 per 28 days) |
| NAFTIN TOPICAL GEL 2 % | 3 | MO; QL (60 per 28 days) |
| *nyamyc* | 1 | MO; QL (180 per 30 days) |
| *nystatin topical cream* | 1 | MO; QL (30 per 28 days) |
| *nystatin topical ointment* | 1 | MO; QL (30 per 28 days) |
| *nystatin topical powder* | 1 | QL (180 per 30 days) |
| *nystatin-triamcinolone* | 1 | MO; QL (60 per 28 days) |
| *nystop* | 1 | MO; QL (180 per 30 days) |
| *tavaborole* | 1 | MO |
| **TOPICAL ANTIVIRALS** | | |
| *acyclovir topical ointment* | 1 | PA; MO; QL (30 per 30 days) |
| DENAVIR | 3 | MO; QL (5 per 30 days) |

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **TOPICAL CORTICOSTEROIDS** | | |
| *ala-cort topical cream 1 %* | 1 | MO |
| *ala-cort topical cream 2.5 %* | 1 | |
| *alclometasone* | 1 | MO |
| *betamethasone dipropionate* | 1 | MO |
| *betamethasone valerate topical cream* | 1 | MO |
| *betamethasone valerate topical lotion* | 1 | MO |
| *betamethasone valerate topical ointment* | 1 | MO |
| *betamethasone, augmented* | 1 | MO |
| *clobetasol scalp* | 1 | MO; QL (100 per 28 days) |
| *clobetasol topical cream* | 1 | MO; QL (120 per 28 days) |
| *clobetasol topical foam* | 1 | MO; QL (100 per 28 days) |
| *clobetasol topical gel* | 1 | MO; QL (120 per 28 days) |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *clobetasol topical lotion* | 1 | MO; QL (118 per 28 days) |
| *clobetasol topical ointment* | 1 | MO; QL (120 per 28 days) |
| *clobetasol topical shampoo* | 1 | MO; QL (236 per 28 days) |
| *clobetasol-emollient topical cream* | 1 | MO; QL (120 per 28 days) |
| *clodan* | 1 | MO; QL (236 per 28 days) |
| *desonide* | 1 | MO |
| *fluocinolone and shower cap* | 1 | MO |
| *fluocinolone topical cream* | 1 | MO |
| *fluocinolone topical ointment* | 1 | MO |
| *fluocinolone topical solution* | 1 | MO |
| *fluocinonide topical cream 0.05 %* | 1 | MO; QL (120 per 30 days) |
| *fluocinonide topical gel* | 1 | MO; QL (120 per 30 days) |
| *fluocinonide topical ointment* | 1 | MO; QL (120 per 30 days) |
| *fluocinonide topical solution* | 1 | MO; QL (120 per 30 days) |
| *fluocinonide-e* | 1 | MO; QL (120 per 30 days) |
| *halobetasol propionate topical cream* | 1 | MO |
| *halobetasol propionate topical ointment* | 1 | MO |
| *hydrocortisone topical cream 1 %* | 1 | MO |
| *hydrocortisone topical lotion 2.5 %* | 1 | MO |
| *hydrocortisone topical ointment 1 %, 2.5 %* | 1 | MO |
| *mometasone topical* | 1 | MO |
| *prednicarbate topical ointment* | 1 | MO |
| *triamcinolone acetonide topical cream* | 1 | MO |
| *triamcinolone acetonide topical lotion* | 1 | MO |
| *triamcinolone acetonide topical ointment 0.025 %, 0.1 %, 0.5 %* | 1 | MO |
| *triderm topical cream* | 1 | MO |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **TOPICAL SCABICIDES / PEDICULICIDES** | | |
| *ivermectin topical lotion* | 1 | MO |
| *lindane topical shampoo* | 1 | MO |
| *malathion* | 1 | MO |
| *permethrin* | 1 | MO |
| **DIAGNOSTICS / MISCELLANEOUS AGENTS** | | |
| **MISCELLANEOUS AGENTS** | | |
| *acamprosate* | 1 | MO |
| *anagrelide* | 1 | MO |
| CARBAGLU | 4 | PA; MO; LA |
| *cevimeline* | 1 | MO |
| CHEMET | 2 | PA |
| CLINIMIX 4.25%/D5W SULFIT FREE | 3 | PA |
| *clovique* | 4 | PA; MO |
| *d10 %-0.45 % sodium chloride* | 1 | |
| *d2.5 %-0.45 % sodium chloride* | 1 | |
| *d5 % and 0.9 % sodium chloride* | 1 | MO |
| *d5 %-0.45 % sodium chloride* | 1 | MO |
| *deferasirox* | 4 | PA; MO |
| *deferiprone* | 4 | PA; MO |
| *dextrose 10 % and 0.2 % nacl* | 1 | |
| *dextrose 10 % in water (d10w)* | 1 | |
| *dextrose 5 % in water (d5w) intravenous piggyback* | 1 | MO |
| *dextrose 5%-0.2 % sod chloride* | 1 | |
| *disulfiram* | 1 | MO |
| *droxidopa* | 4 | PA; MO |
| FERRIPROX | 4 | PA |
| INCRELEX | 4 | MO; LA |
| *levocarnitine (with sugar)* | 1 | MO |
| *levocarnitine oral tablet* | 1 | MO |
| LOKELMA | 2 | MO |
| *midodrine* | 1 | MO |
| *nitisinone* | 4 | PA; MO |
| *pilocarpine hcl oral* | 1 | MO |
| PROLASTIN-C | 4 | PA; LA |
| RAVICTI | 4 | PA; MO |
| *riluzole* | 1 | PA; MO |

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|---|---|---|
| *risedronate oral tablet 30 mg* | 1 | MO; QL (30 per 30 days) |
| *sevelamer carbonate oral tablet* | 1 | MO; QL (270 per 30 days) |
| *sodium chloride 0.9 % intravenous piggyback* | 1 | MO |
| *sodium chloride irrigation* | 1 | MO |
| *sodium phenylbutyrate oral powder* | 4 | PA; MO |
| *sodium phenylbutyrate oral tablet* | 4 | PA |
| *sodium polystyrene sulfonate oral powder* | 1 | MO |
| *sps (with sorbitol) oral* | 1 | MO |
| *trientine* | 4 | PA; MO |
| VELTASSA | 2 | MO |
| XURIDEN | 4 | PA |
| **SMOKING DETERRENTS** | | |
| *bupropion hcl (smoking deter)* | 1 | MO |
| CHANTIX | 3 | MO |
| CHANTIX CONTINUING MONTH BOX | 3 | MO |
| CHANTIX STARTING MONTH BOX | 3 | MO |
| NICOTROL | 3 | MO |
| NICOTROL NS | 3 | MO |
| **EAR, NOSE / THROAT MEDICATIONS** | | |
| **MISCELLANEOUS AGENTS** | | |
| *azelastine nasal* | 1 | MO; QL (60 per 30 days) |
| *chlorhexidine gluconate mucous membrane* | 1 | MO |
| *ipratropium bromide nasal* | 1 | MO; QL (30 per 30 days) |
| *periogard* | 1 | MO |
| *triamcinolone acetonide dental* | 1 | MO |
| **MISCELLANEOUS OTIC PREPARATIONS** | | |
| *acetic acid otic (ear)* | 1 | MO |
| *ciprofloxacin hcl otic (ear)* | 1 | MO |
| *flac otic oil* | 1 | |

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|---|---|---|
| *fluocinolone acetonide oil* | 1 | MO |
| *hydrocortisone-acetic acid* | 1 | MO |
| *ofloxacin otic (ear)* | 1 | MO |
| **OTIC STEROID / ANTIBIOTIC** | | |
| *ciprofloxacin-dexamethasone* | 1 | MO |
| *neomycin-polymyxin-hc otic (ear)* | 1 | MO |
| **ENDOCRINE/ DIABETES** | | |
| **ADRENAL HORMONES** | | |
| *dexamethasone oral elixir* | 1 | MO |
| *dexamethasone oral tablet* | 1 | MO |
| *fludrocortisone* | 1 | MO |
| *hydrocortisone oral* | 1 | MO |
| *methylprednisolone oral tablet* | 1 | PA; MO |
| *methylprednisolone oral tablets,dose pack* | 1 | MO |
| *prednisolone oral solution* | 1 | MO |
| *prednisolone sodium phosphate oral solution 25 mg/5 ml (5 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)* | 1 | MO |
| *prednisone* | 1 | MO |
| *prednisone intensol* | 1 | MO |
| **ANTITHYROID AGENTS** | | |
| *methimazole oral tablet 10 mg, 5 mg* | 1 | MO |
| *propylthiouracil* | 1 | MO |
| **DIABETES THERAPY** | | |
| *acarbose oral tablet 100 mg* | 1 | MO; QL (90 per 30 days) |
| *acarbose oral tablet 25 mg* | 1 | MO; QL (360 per 30 days) |
| *acarbose oral tablet 50 mg* | 1 | MO; QL (180 per 30 days) |
| ALCOHOL PADS | 2 | |
| BAQSIMI | 2 | MO |
| BYDUREON BCISE | 2 | PA; MO; QL (4 per 28 days) |

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|---|---|---|
| BYETTA SUBCUTANEOUS PEN INJECTOR 10 MCG/DOSE(250 MCG/ML) 2.4 ML | 2 | PA; MO; QL (2.4 per 30 days) |
| BYETTA SUBCUTANEOUS PEN INJECTOR 5 MCG/DOSE (250 MCG/ML) 1.2 ML | 2 | PA; MO; QL (1.2 per 30 days) |
| *diazoxide* | 1 | MO |
| FARXIGA ORAL TABLET 10 MG | 2 | MO; QL (30 per 30 days) |
| FARXIGA ORAL TABLET 5 MG | 2 | MO; QL (60 per 30 days) |
| *glimepiride oral tablet 1 mg* | 1 | MO; QL (240 per 30 days) |
| *glimepiride oral tablet 2 mg* | 1 | MO; QL (120 per 30 days) |
| *glimepiride oral tablet 4 mg* | 1 | MO; QL (60 per 30 days) |
| *glipizide oral tablet 10 mg* | 1 | MO; QL (120 per 30 days) |
| *glipizide oral tablet 5 mg* | 1 | MO; QL (240 per 30 days) |
| *glipizide oral tablet extended release 24hr 10 mg* | 1 | MO; QL (60 per 30 days) |
| *glipizide oral tablet extended release 24hr 2.5 mg* | 1 | MO; QL (240 per 30 days) |
| *glipizide oral tablet extended release 24hr 5 mg* | 1 | MO; QL (120 per 30 days) |
| *glipizide-metformin oral tablet 2.5-250 mg* | 1 | MO; QL (240 per 30 days) |
| *glipizide-metformin oral tablet 2.5-500 mg, 5-500 mg* | 1 | MO; QL (120 per 30 days) |
| GLYXAMBI | 2 | MO; QL (30 per 30 days) |
| GVOKE HYPOPEN 2-PACK | 2 | MO |
| GVOKE PFS 1-PACK SYRINGE | 2 | MO |
| HUMALOG JUNIOR KWIKPEN U-100 | 2 | MO |
| HUMALOG KWIKPEN INSULIN | 2 | MO |
| HUMALOG MIX 50-50 INSULN U-100 | 2 | MO |
| HUMALOG MIX 50-50 KWIKPEN | 2 | MO |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| HUMALOG MIX 75-25 KWIKPEN | 2 | MO |
| HUMALOG MIX 75-25(U-100)INSULN | 2 | MO |
| HUMALOG U-100 INSULIN | 2 | MO |
| HUMULIN 70/30 U-100 INSULIN | 2 | MO |
| HUMULIN 70/30 U-100 KWIKPEN | 2 | MO |
| HUMULIN N NPH INSULIN KWIKPEN | 2 | MO |
| HUMULIN N NPH U-100 INSULIN | 2 | MO |
| HUMULIN R REGULAR U-100 INSULN | 2 | MO |
| HUMULIN R U-500 (CONC) INSULIN | 2 | MO |
| HUMULIN R U-500 (CONC) KWIKPEN | 2 | MO |
| JANUMET | 2 | MO; QL (60 per 30 days) |
| JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 100-1,000 MG | 2 | MO; QL (30 per 30 days) |
| JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 50-1,000 MG, 50-500 MG | 2 | MO; QL (60 per 30 days) |
| JANUVIA | 2 | MO; QL (30 per 30 days) |
| JARDIANCE | 2 | MO; QL (30 per 30 days) |
| KOMBIGLYZE XR ORAL TABLET, ER MULTIPHASE 24 HR 2.5-1,000 MG | 2 | MO; QL (60 per 30 days) |
| KOMBIGLYZE XR ORAL TABLET, ER MULTIPHASE 24 HR 5-1,000 MG, 5-500 MG | 2 | MO; QL (30 per 30 days) |
| LANTUS SOLOSTAR U-100 INSULIN | 2 | MO |
| LANTUS U-100 INSULIN | 2 | MO |
| LYUMJEV KWIKPEN U-100 INSULIN | 2 | MO |
| LYUMJEV KWIKPEN U-200 INSULIN | 2 | MO |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| LYUMJEV U-100 INSULIN | 2 | MO |
| *metformin oral tablet 1,000 mg* | 1 | MO; QL (75 per 30 days) |
| *metformin oral tablet 500 mg* | 1 | MO; QL (150 per 30 days) |
| *metformin oral tablet 850 mg* | 1 | MO; QL (90 per 30 days) |
| *metformin oral tablet extended release 24 hr 500 mg* | 1 | MO; QL (120 per 30 days) |
| *metformin oral tablet extended release 24 hr 750 mg* | 1 | MO; QL (60 per 30 days) |
| *nateglinide oral tablet 120 mg* | 1 | MO; QL (90 per 30 days) |
| *nateglinide oral tablet 60 mg* | 1 | MO; QL (180 per 30 days) |
| ONGLYZA | 2 | MO; QL (30 per 30 days) |
| OZEMPIC SUBCUTANEOUS PEN INJECTOR 0.25 MG OR 0.5 MG(2 MG/1.5 ML) | 2 | PA; MO; QL (1.5 per 28 days) |
| OZEMPIC SUBCUTANEOUS PEN INJECTOR 1 MG/DOSE (2 MG/1.5 ML) | 2 | PA; QL (3 per 28 days) |
| OZEMPIC SUBCUTANEOUS PEN INJECTOR 1 MG/DOSE (4 MG/3 ML) | 2 | PA; MO; QL (3 per 28 days) |
| *pioglitazone* | 1 | MO; QL (30 per 30 days) |
| QTERN | 2 | MO; QL (30 per 30 days) |
| *repaglinide oral tablet 0.5 mg* | 1 | MO; QL (960 per 30 days) |
| *repaglinide oral tablet 1 mg* | 1 | MO; QL (480 per 30 days) |
| *repaglinide oral tablet 2 mg* | 1 | MO; QL (240 per 30 days) |
| RYBELSUS | 2 | PA; MO; QL (30 per 30 days) |
| SEGLUROMET ORAL TABLET 2.5-1,000 MG, 7.5-1,000 MG, 7.5-500 MG | 2 | MO; QL (60 per 30 days) |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| SEGLUROMET ORAL TABLET 2.5-500 MG | 2 | MO; QL (120 per 30 days) |
| SOLIQUA 100/33 | 2 | MO; QL (90 per 30 days) |
| STEGLATRO | 2 | MO; QL (30 per 30 days) |
| SYMLINPEN 120 | 4 | PA; MO; QL (10.8 per 30 days) |
| SYMLINPEN 60 | 4 | PA; MO; QL (6 per 30 days) |
| SYNJARDY | 2 | MO; QL (60 per 30 days) |
| SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 12.5-1,000 MG, 5-1,000 MG | 2 | MO; QL (60 per 30 days) |
| SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 25-1,000 MG | 2 | MO; QL (30 per 30 days) |
| TOUJEO MAX U-300 SOLOSTAR | 2 | MO |
| TOUJEO SOLOSTAR U-300 INSULIN | 2 | MO |
| TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-5-1,000 MG, 25-5-1,000 MG | 2 | MO; QL (30 per 30 days) |
| TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 12.5-2.5-1,000 MG, 5-2.5-1,000 MG | 2 | MO; QL (60 per 30 days) |
| TRULICITY | 2 | PA; MO; QL (2 per 28 days) |
| VICTOZA 3-PAK | 2 | PA; MO; QL (9 per 30 days) |
| XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 10-500 MG | 2 | MO; QL (30 per 30 days) |
| XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG, 5-1,000 MG, 5-500 MG | 2 | MO; QL (60 per 30 days) |
| XULTOPHY 100/3.6 | 2 | MO; QL (15 per 30 days) |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **MISCELLANEOUS HORMONES** | | |
| ANDRODERM | 2 | PA; MO; QL (30 per 30 days) |
| *cabergoline* | 1 | MO |
| *calcitonin (salmon) nasal* | 1 | MO |
| *calcitriol oral capsule* | 1 | MO |
| *calcitriol oral solution* | 1 | |
| CERDELGA | 4 | PA; MO |
| *cinacalcet oral tablet 30 mg* | 1 | PA; MO |
| *cinacalcet oral tablet 60 mg, 90 mg* | 4 | PA; MO |
| *danazol* | 1 | MO |
| *desmopressin nasal spray with pump* | 1 | MO |
| *desmopressin oral* | 1 | MO |
| *doxercalciferol oral* | 1 | MO |
| KORLYM | 4 | PA |
| *miglustat* | 4 | PA; MO; LA |
| MYALEPT | 4 | PA; MO; LA |
| NATPARA | 4 | PA; MO; LA |
| *oxandrolone* | 1 | PA; MO |
| PALYNZIQ SUBCUTANEOUS SYRINGE 10 MG/0.5 ML | 4 | PA; MO; LA; QL (15 per 30 days) |
| PALYNZIQ SUBCUTANEOUS SYRINGE 2.5 MG/0.5 ML | 4 | PA; MO; LA; QL (4 per 30 days) |
| PALYNZIQ SUBCUTANEOUS SYRINGE 20 MG/ML | 4 | PA; MO; LA; QL (60 per 30 days) |
| *paricalcitol oral* | 1 | MO |
| SAMSCA ORAL TABLET 15 MG | 4 | PA; MO |
| *sapropterin* | 4 | PA; MO |
| SOMAVERT | 4 | PA; MO |
| STRENSIQ SUBCUTANEOUS SOLUTION 28 MG/0.7 ML, 40 MG/ML, 80 MG/0.8 ML | 4 | PA; LA |
| SYNAREL | 4 | PA; MO |
| *testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml, 200 mg/ml (1 ml)* | 1 | PA; MO |
| *testosterone enanthate* | 1 | PA; MO |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *testosterone transdermal gel in metered-dose pump 10 mg/0.5 gram /actuation* | 1 | PA; MO; QL (120 per 30 days) |
| *testosterone transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)* | 1 | PA; MO; QL (150 per 30 days) |
| *testosterone transdermal gel in packet 1 % (25 mg/2.5gram), 1 % (50 mg/5 gram)* | 1 | PA; MO; QL (300 per 30 days) |
| *testosterone transdermal gel in packet 1.62 % (20.25 mg/1.25 gram)* | 1 | PA; MO; QL (37.5 per 30 days) |
| *testosterone transdermal gel in packet 1.62 % (40.5 mg/2.5 gram)* | 1 | PA; MO; QL (150 per 30 days) |
| *testosterone transdermal solution in metered pump w/app* | 1 | PA; MO; QL (180 per 30 days) |
| *tolvaptan oral tablet 30 mg* | 4 | PA; MO |
| **THYROID HORMONES** | | |
| *euthyrox* | 1 | MO |
| *levo-t* | 1 | |
| *levothyroxine oral tablet* | 1 | |
| *levoxyl oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 50 mcg, 75 mcg, 88 mcg* | 1 | MO |
| *liothyronine oral* | 1 | MO |
| *unithroid* | 1 | MO |
| **GASTROENTEROLOGY** | | |
| **ANTIDIARRHEALS / ANTISPASMODICS** | | |
| *dicyclomine oral capsule* | 1 | MO |
| *dicyclomine oral solution* | 1 | MO |
| *dicyclomine oral tablet* | 1 | MO |
| *diphenoxylate-atropine* | 1 | MO |
| *glycopyrrolate oral tablet 1 mg, 2 mg* | 1 | MO |
| *loperamide oral capsule* | 1 | MO |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **MISCELLANEOUS GASTROINTESTINAL AGENTS** | | |
| *alosetron* | 4 | PA; MO |
| *aprepitant* | 1 | PA; MO |
| *balsalazide* | 1 | MO |
| *budesonide oral capsule,delayed,extend.release* | 1 | MO |
| *budesonide oral tablet,delayed and ext.release* | 4 | |
| CHENODAL | 4 | PA; LA |
| CHOLBAM ORAL CAPSULE 250 MG | 4 | PA |
| CHOLBAM ORAL CAPSULE 50 MG | 4 | PA; QL (120 per 30 days) |
| CIMZIA | 4 | PA; MO; QL (2 per 28 days) |
| CIMZIA POWDER FOR RECONST | 4 | PA; MO; QL (2 per 28 days) |
| *compro* | 1 | MO |
| *constulose* | 1 | MO |
| CORTIFOAM | 2 | MO |
| CREON | 2 | MO |
| *cromolyn oral* | 1 | MO |
| CYSTADANE | 4 | |
| DIPENTUM | 4 | MO |
| *dronabinol* | 1 | PA; MO |
| EMEND ORAL SUSPENSION FOR RECONSTITUTION | 3 | PA |
| *enulose* | 1 | MO |
| GATTEX 30-VIAL | 4 | PA; MO |
| *gavilyte-c* | 1 | MO |
| *gavilyte-g* | 1 | MO |
| *gavilyte-n* | 1 | MO |
| *generlac* | 1 | MO |
| *granisetron hcl oral* | 1 | PA; MO |
| *hydrocortisone rectal* | 1 | MO |
| *hydrocortisone topical cream with perineal applicator 2.5 %* | 1 | MO |
| *lactulose oral solution 10 gram/15 ml* | 1 | MO |
| LINZESS | 2 | MO; QL (30 per 30 days) |
| *meclizine oral tablet 12.5 mg, 25 mg* | 1 | MO |
| *mesalamine oral capsule (with del rel tablets)* | 1 | MO |
| *mesalamine oral capsule,extended release 24hr* | 1 | |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *mesalamine oral tablet,delayed release (dr/ec)* | 1 | MO |
| *mesalamine rectal* | 1 | MO |
| *metoclopramide hcl oral solution* | 1 | MO |
| *metoclopramide hcl oral tablet* | 1 | MO |
| MOTEGRITY | 3 | ST; MO; QL (30 per 30 days) |
| MOVANTIK | 2 | MO; QL (30 per 30 days) |
| OCALIVA | 4 | PA; MO; LA; QL (30 per 30 days) |
| *ondansetron* | 1 | PA; MO |
| *ondansetron hcl oral solution* | 1 | PA; MO |
| *ondansetron hcl oral tablet 4 mg, 8 mg* | 1 | PA; MO |
| *peg 3350-electrolytes oral recon soln 236-22.74-6.74 -5.86 gram* | 1 | MO |
| *peg3350-sod sul-nacl-kcl-asb-c* | 1 | MO |
| *peg-electrolyte* | 1 | MO |
| PENTASA ORAL CAPSULE, EXTENDED RELEASE 250 MG | 2 | MO |
| PENTASA ORAL CAPSULE, EXTENDED RELEASE 500 MG | 4 | MO |
| *prochlorperazine* | 1 | MO |
| *prochlorperazine maleate oral* | 1 | MO |
| *procto-med hc* | 1 | MO |
| *procto-pak* | 1 | MO |
| *proctosol hc topical* | 1 | MO |
| *proctozone-hc* | 1 | MO |
| RECTIV | 2 | MO |
| RELISTOR SUBCUTANEOUS SOLUTION | 4 | MO; QL (18 per 30 days) |
| RELISTOR SUBCUTANEOUS SYRINGE 12 MG/0.6 ML | 4 | MO; QL (18 per 30 days) |
| RELISTOR SUBCUTANEOUS SYRINGE 8 MG/0.4 ML | 4 | MO; QL (12 per 30 days) |
| REMICADE | 4 | PA; MO; QL (20 per 28 days) |
| SANCUSO | 4 | MO |
| *scopolamine base* | 1 | MO |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| SUCRAID | 4 | PA |
| *sulfasalazine* | 1 | MO |
| *trilyte with flavor packets* | 1 | MO |
| TRULANCE | 2 | MO |
| *ursodiol* | 1 | MO |
| VARUBI ORAL | 2 | PA |
| VIOKACE | 2 | MO |
| ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 10,000-32,000 - 42,000 UNIT, 15,000-47,000 - 63,000 UNIT, 20,000-63,000-84,000 UNIT, 25,000-79,000-105,000 UNIT, 3,000-10,000 - 14,000-UNIT, 40,000-126,000-168,000 UNIT, 5,000-17,000-24,000 UNIT | 2 | MO |
| **ULCER THERAPY** | | |
| *cimetidine* | 1 | MO |
| *cimetidine hcl oral* | 1 | MO |
| *esomeprazole magnesium oral capsule,delayed release(dr/ec) 20 mg* | 1 | MO; QL (30 per 30 days) |
| *esomeprazole magnesium oral capsule,delayed release(dr/ec) 40 mg* | 1 | MO |
| *famotidine oral suspension* | 1 | MO |
| *famotidine oral tablet 20 mg, 40 mg* | 1 | MO |
| *lansoprazole oral capsule,delayed release(dr/ec) 15 mg* | 1 | MO; QL (30 per 30 days) |
| *lansoprazole oral capsule,delayed release(dr/ec) 30 mg* | 1 | MO |
| *misoprostol* | 1 | MO |
| *nizatidine oral capsule* | 1 | |
| *nizatidine oral solution* | 1 | MO |
| *omeprazole oral capsule,delayed release(dr/ec) 10 mg, 20 mg* | 1 | MO; QL (30 per 30 days) |
| *omeprazole oral capsule,delayed release(dr/ec) 40 mg* | 1 | MO |

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|---|---|---|
| *pantoprazole oral tablet,delayed release (dr/ec) 20 mg* | 1 | MO; QL (30 per 30 days) |
| *pantoprazole oral tablet,delayed release (dr/ec) 40 mg* | 1 | MO |
| *sucralfate* | 1 | MO |
| **IMMUNOLOGY, VACCINES / BIOTECHNOLOGY** | | |
| **BIOTECHNOLOGY DRUGS** | | |
| ACTIMMUNE | 4 | PA; MO |
| ARCALYST | 4 | PA; MO |
| AVONEX INTRAMUSCULAR PEN INJECTOR KIT | 4 | PA; MO; QL (1 per 28 days) |
| AVONEX INTRAMUSCULAR SYRINGE KIT | 4 | PA; MO; QL (1 per 28 days) |
| BETASERON SUBCUTANEOUS KIT | 4 | PA; MO; QL (14 per 28 days) |
| INTRON A INJECTION | 4 | PA; MO |
| LEUKINE INJECTION RECON SOLN | 4 | PA; MO |
| NIVESTYM | 4 | PA; MO |
| NYVEPRIA | 4 | PA; MO |
| OMNITROPE | 4 | PA; MO |
| PEGASYS SUBCUTANEOUS SOLUTION | 4 | MO; QL (4 per 28 days) |
| PEGASYS SUBCUTANEOUS SYRINGE | 4 | MO; QL (2 per 28 days) |
| PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML | 4 | PA; MO; QL (1 per 28 days) |
| PLEGRIDY SUBCUTANEOUS PEN INJECTOR 63 MCG/0.5 ML-94 MCG/0.5 ML | 4 | PA; MO; QL (1 per 180 days) |
| PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML | 4 | PA; MO; QL (1 per 28 days) |
| PLEGRIDY SUBCUTANEOUS SYRINGE 63 MCG/0.5 ML- 94 MCG/0.5 ML | 4 | PA; MO; QL (1 per 180 days) |

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|---|---|---|
| PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML | 2 | PA; MO |
| PROCRIT INJECTION SOLUTION 20,000 UNIT/ML, 40,000 UNIT/ML | 4 | PA; MO |
| RETACRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 3,000 UNIT/ML, 4,000 UNIT/ML | 2 | PA; MO |
| RETACRIT INJECTION SOLUTION 20,000 UNIT/ML, 40,000 UNIT/ML | 4 | PA; MO |
| ZARXIO | 4 | PA; MO |
| ZIEXTENZO | 4 | PA; MO |
| **VACCINES / MISCELLANEOUS IMMUNOLOGICALS** | | |
| ACTHIB (PF) | 2 | MO |
| ADACEL(TDAP ADOLESN/ADULT)(PF) | 2 | MO |
| BCG VACCINE, LIVE (PF) | 2 | MO |
| BEXSERO | 2 | MO |
| BOOSTRIX TDAP | 2 | MO |
| DAPTACEL (DTAP PEDIATRIC) (PF) | 2 | MO |
| ENGERIX-B (PF) INTRAMUSCULAR SYRINGE | 2 | PA; MO |
| ENGERIX-B PEDIATRIC (PF) | 2 | PA; MO |
| GARDASIL 9 (PF) | 2 | MO |
| HAVRIX (PF) INTRAMUSCULAR SYRINGE | 2 | MO |
| HIBERIX (PF) | 2 | MO |
| IMOVAX RABIES VACCINE (PF) | 2 | |
| INFANRIX (DTAP) (PF) INTRAMUSCULAR SYRINGE | 2 | MO |
| IPOL | 2 | |
| IXIARO (PF) | 2 | |
| KINRIX (PF) INTRAMUSCULAR SUSPENSION | 2 | |
| KINRIX (PF) INTRAMUSCULAR SYRINGE | 2 | MO |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| MENACTRA (PF) INTRAMUSCULAR SOLUTION | 2 | MO |
| MENQUADFI (PF) | 2 | MO |
| MENVEO A-C-Y-W-135-DIP (PF) | 2 | MO |
| M-M-R II (PF) | 2 | MO |
| PEDIARIX (PF) | 2 | MO |
| PEDVAX HIB (PF) | 2 | |
| PRIVIGEN | 4 | PA; MO |
| PROQUAD (PF) | 2 | |
| QUADRACEL (PF) | 2 | |
| RABAVERT (PF) | 2 | MO |
| RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION 10 MCG/ML, 40 MCG/ML | 2 | PA; MO |
| RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE 10 MCG/ML | 2 | PA; MO |
| RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE 5 MCG/0.5 ML | 2 | PA |
| ROTARIX | 2 | |
| ROTATEQ VACCINE | 2 | MO |
| SHINGRIX (PF) | 2 | MO |
| TDVAX | 2 | MO |
| TENIVAC (PF) INTRAMUSCULAR SYRINGE | 2 | MO |
| TETANUS,DIPHTHERIA TOX PED(PF) | 2 | MO |
| TRUMENBA | 2 | MO |
| TWINRIX (PF) | 2 | MO |
| TYPHIM VI INTRAMUSCULAR SOLUTION | 2 | |
| TYPHIM VI INTRAMUSCULAR SYRINGE | 2 | MO |
| VAQTA (PF) | 2 | MO |
| VARIVAX (PF) | 2 | |
| VARIZIG | 2 | MO |
| YF-VAX (PF) | 2 | |
| **MISCELLANEOUS SUPPLIES** | | |
| **MISCELLANEOUS SUPPLIES** | | |
| BD AUTOSHIELD DUO PEN NEEDLE | 2 | MO |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| BD INSULIN SYRINGE (HALF UNIT) | 2 | MO |
| BD INSULIN SYRINGE U-500 | 2 | MO |
| BD INSULIN ULTRA-FINE SYRINGE 0.3 ML 30 GAUGE X 1/2", 0.5 ML 31 GAUGE X 5/16", 1 ML 30 GAUGE X 1/2" | 2 | MO |
| BD NANO 2ND GEN PEN NEEDLE | 2 | MO |
| BD ULTRA-FINE MICRO PEN NEEDLE | 2 | MO |
| BD ULTRA-FINE MINI PEN NEEDLE | 2 | MO |
| BD ULTRA-FINE NANO PEN NEEDLE | 2 | MO |
| BD ULTRA-FINE SHORT PEN NEEDLE | 2 | MO |
| BD VEO INSULIN SYR (HALF UNIT) | 2 | MO |
| BD VEO INSULIN SYRINGE UF | 2 | MO |
| GAUZE PADS 2 X 2 | 2 | |
| INSULIN PEN NEEDLE | 2 | MO |
| INSULIN SYRINGE (DISP) U-100 0.3 ML, 1/2 ML | 2 | |
| INSULIN SYRINGE (DISP) U-100 1 ML | 2 | MO |
| NEEDLES, INSULIN DISP.,SAFETY | 2 | MO |
| NOVOFINE 32 | 2 | MO |
| NOVOTWIST | 2 | MO |
| OMNIPOD DASH 5 PACK POD | 2 | MO |
| OMNIPOD INSULIN MANAGEMENT | 2 | MO |
| OMNIPOD INSULIN REFILL | 2 | MO |
| V-GO 20 | 2 | MO |
| V-GO 30 | 2 | MO |
| V-GO 40 | 2 | MO |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **MUSCULOSKELETAL / RHEUMATOLOGY** | | |
| **GOUT THERAPY** | | |
| *allopurinol* | 1 | MO |
| *colchicine oral tablet* | 1 | MO |
| *febuxostat* | 1 | MO |
| *probenecid* | 1 | MO |
| *probenecid-colchicine* | 1 | MO |
| **OSTEOPOROSIS THERAPY** | | |
| *alendronate oral solution* | 1 | MO; QL (300 per 28 days) |
| *alendronate oral tablet 10 mg* | 1 | MO; QL (30 per 30 days) |
| *alendronate oral tablet 35 mg, 70 mg* | 1 | MO; QL (4 per 28 days) |
| FOSAMAX PLUS D | 3 | ST; MO; QL (4 per 28 days) |
| *ibandronate oral* | 1 | MO; QL (1 per 30 days) |
| PROLIA | 2 | PA; MO; QL (1 per 180 days) |
| *raloxifene* | 1 | MO |
| *risedronate oral tablet 150 mg* | 1 | MO; QL (1 per 30 days) |
| *risedronate oral tablet 35 mg, 35 mg (12 pack), 35 mg (4 pack)* | 1 | MO; QL (4 per 28 days) |
| *risedronate oral tablet 5 mg* | 1 | MO; QL (30 per 30 days) |
| *risedronate oral tablet,delayed release (dr/ec)* | 1 | MO; QL (4 per 28 days) |
| TERIPARATIDE | 4 | PA; MO; QL (2.48 per 28 days) |
| **OTHER RHEUMATOLOGICALS** | | |
| ACTEMRA ACTPEN | 4 | PA; MO; QL (3.6 per 28 days) |
| ACTEMRA SUBCUTANEOUS | 4 | PA; MO; QL (3.6 per 28 days) |
| BENLYSTA SUBCUTANEOUS | 4 | PA; MO |
| ENBREL MINI | 4 | PA; MO; QL (8 per 28 days) |
| ENBREL SUBCUTANEOUS RECON SOLN | 4 | PA; MO; QL (16 per 28 days) |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| ENBREL SUBCUTANEOUS SOLUTION | 4 | PA; MO; QL (8 per 28 days) |
| ENBREL SUBCUTANEOUS SYRINGE | 4 | PA; MO; QL (8 per 28 days) |
| ENBREL SURECLICK | 4 | PA; MO; QL (8 per 28 days) |
| HUMIRA PEN | 4 | PA; MO; QL (4 per 28 days) |
| HUMIRA PEN CROHNS-UC-HS START | 4 | PA; MO; QL (6 per 180 days) |
| HUMIRA PEN PSOR-UVEITS-ADOL HS | 4 | PA; MO; QL (4 per 180 days) |
| HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML | 4 | PA; MO; QL (4 per 28 days) |
| HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML | 4 | PA; MO; QL (3 per 180 days) |
| HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML-40 MG/0.4 ML | 4 | PA; MO; QL (2 per 180 days) |
| HUMIRA(CF) PEN CROHNS-UC-HS | 4 | PA; MO; QL (3 per 180 days) |
| HUMIRA(CF) PEN PEDIATRIC UC | 4 | PA; MO; QL (4 per 28 days) |
| HUMIRA(CF) PEN PSOR-UV-ADOL HS | 4 | PA; MO; QL (3 per 180 days) |
| HUMIRA(CF) SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML | 4 | PA; MO; QL (4 per 28 days) |
| HUMIRA(CF) SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML | 4 | PA; MO; QL (2 per 28 days) |
| HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 10 MG/0.1 ML, 20 MG/0.2 ML | 4 | PA; MO; QL (2 per 28 days) |
| HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML | 4 | PA; MO; QL (4 per 28 days) |
| *leflunomide* | 1 | MO; QL (30 per 30 days) |
| ORENCIA CLICKJECT | 4 | PA; MO; QL (4 per 28 days) |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| ORENCIA SUBCUTANEOUS SYRINGE 125 MG/ML | 4 | PA; MO; QL (4 per 28 days) |
| ORENCIA SUBCUTANEOUS SYRINGE 50 MG/0.4 ML | 4 | PA; MO; QL (1.6 per 28 days) |
| ORENCIA SUBCUTANEOUS SYRINGE 87.5 MG/0.7 ML | 4 | PA; MO; QL (2.8 per 28 days) |
| OTEZLA | 4 | PA; MO; QL (60 per 30 days) |
| OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47) | 4 | PA; MO; QL (55 per 28 days) |
| *penicillamine oral tablet* | 4 | PA; MO |
| RIDAURA | 4 | MO |
| RINVOQ | 4 | PA; MO; QL (30 per 30 days) |
| SAVELLA ORAL TABLET | 2 | MO; QL (60 per 30 days) |
| SAVELLA ORAL TABLETS,DOSE PACK | 2 | MO; QL (55 per 30 days) |
| XELJANZ ORAL SOLUTION | 4 | PA; MO; QL (300 per 30 days) |
| XELJANZ ORAL TABLET | 4 | PA; MO; QL (60 per 30 days) |
| XELJANZ XR | 4 | PA; MO; QL (30 per 30 days) |
| **OBSTETRICS / GYNECOLOGY** | | |
| **ESTROGENS / PROGESTINS** | | |
| *amabelz* | 1 | PA; MO |
| *camila* | 1 | MO |
| CRINONE VAGINAL GEL 4 % | 3 | MO |
| CRINONE VAGINAL GEL 8 % | 3 | PA; MO |
| *deblitane* | 1 | MO |
| DEPO-SUBQ PROVERA 104 | 3 | MO |
| *dotti* | 1 | PA; MO; QL (8 per 28 days) |
| DUAVEE | 2 | MO |
| *errin* | 1 | MO |
| *estradiol oral* | 1 | PA; MO |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *estradiol transdermal patch semiweekly* | 1 | PA; MO; QL (8 per 28 days) |
| *estradiol transdermal patch weekly* | 1 | PA; QL (4 per 28 days) |
| *estradiol vaginal* | 1 | MO |
| *estradiol valerate intramuscular oil 20 mg/ml, 40 mg/ml* | 1 | MO |
| *estradiol-norethindrone acet* | 1 | PA; MO |
| ESTRING | 2 | MO |
| *fyavolv* | 1 | PA; MO |
| *incassia* | 1 | MO |
| *jinteli* | 1 | PA; MO |
| *lyllana* | 1 | PA; MO; QL (8 per 28 days) |
| *lyza* | 1 | |
| *medroxyprogesterone* | 1 | MO |
| MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG | 2 | PA; MO |
| *mimvey* | 1 | PA; MO |
| *nora-be* | 1 | MO |
| *norethindrone (contraceptive)* | 1 | |
| *norethindrone acetate* | 1 | MO |
| *norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg* | 1 | PA |
| *norethindrone ac-eth estradiol oral tablet 1-5 mg-mcg* | 1 | PA; MO |
| PREMARIN ORAL | 2 | MO |
| PREMARIN VAGINAL | 2 | MO |
| PREMPHASE | 2 | MO |
| PREMPRO | 2 | MO |
| *progesterone micronized* | 1 | MO |
| *sharobel* | 1 | MO |
| *yuvafem* | 1 | MO |
| **MISCELLANEOUS OB/GYN** | | |
| CLEOCIN VAGINAL SUPPOSITORY | 3 | MO |
| *clindamycin phosphate vaginal* | 1 | MO |
| *eluryng* | 1 | MO |
| *etonogestrel-ethinyl estradiol* | 1 | |
| *metronidazole vaginal* | 1 | MO |
| *terconazole* | 1 | MO |
| *tranexamic acid oral* | 1 | MO |
| *vandazole* | 1 | MO |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *xulane* | 1 | MO |
| *zafemy* | 1 | MO |
| **ORAL CONTRACEPTIVES / RELATED AGENTS** | | |
| *altavera (28)* | 1 | MO |
| *alyacen 1/35 (28)* | 1 | MO |
| *apri* | 1 | MO |
| *aranelle (28)* | 1 | MO |
| *aubra eq* | 1 | MO |
| *aviane* | 1 | MO |
| *caziant (28)* | 1 | MO |
| *cryselle (28)* | 1 | MO |
| *cyclafem 1/35 (28)* | 1 | MO |
| *cyclafem 7/7/7 (28)* | 1 | MO |
| *cyred eq* | 1 | MO |
| *desog-e.estradiol/e.estradiol* | 1 | |
| *desogestrel-ethinyl estradiol* | 1 | |
| *drospirenone-ethinyl estradiol oral tablet 3-0.02 mg* | 1 | MO |
| *drospirenone-ethinyl estradiol oral tablet 3-0.03 mg* | 1 | |
| *emoquette* | 1 | MO |
| *enpresse* | 1 | MO |
| *enskyce* | 1 | MO |
| *estarylla* | 1 | MO |
| *ethynodiol diac-eth estradiol* | 1 | |
| *falmina (28)* | 1 | MO |
| *fayosim* | 1 | MO |
| *femynor* | 1 | MO |
| *introvale* | 1 | MO |
| *isibloom* | 1 | MO |
| *jasmiel (28)* | 1 | MO |
| *juleber* | 1 | MO |
| *kariva (28)* | 1 | MO |
| *kelnor 1/35 (28)* | 1 | MO |
| *kelnor 1-50 (28)* | 1 | MO |
| *kurvelo (28)* | 1 | MO |
| *l norgest/e.estradiol-e.estrad oral tablets,dose pack,3 month 0.10 mg-20 mcg (84)/10 mcg (7), 0.15 mg-30 mcg (84)/10 mcg (7)* | 1 | |
| *l norgest/e.estradiol-e.estrad oral tablets,dose pack,3 month 0.15 mg-20 mcg/ 0.15 mg-25 mcg* | 1 | MO |
| *larin 1.5/30 (21)* | 1 | MO |
| *larin 1/20 (21)* | 1 | MO |
| *larin fe 1.5/30 (28)* | 1 | MO |
| *larin fe 1/20 (28)* | 1 | MO |
| *larissia* | 1 | MO |
| *lessina* | 1 | MO |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *levonest (28)* | 1 | MO |
| *levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg* | 1 | MO |
| *levonorgestrel-ethinyl estrad oral tablet 0.15-0.03 mg, 90-20 mcg (28)* | 1 | |
| *levonorgestrel-ethinyl estrad oral tablets,dose pack,3 month* | 1 | MO |
| *levonorg-eth estrad triphasic* | 1 | MO |
| *levora-28* | 1 | MO |
| *loryna (28)* | 1 | MO |
| *low-ogestrel (28)* | 1 | MO |
| *lutera (28)* | 1 | MO |
| *marlissa (28)* | 1 | MO |
| *microgestin 1.5/30 (21)* | 1 | MO |
| *microgestin 1/20 (21)* | 1 | MO |
| *microgestin fe 1.5/30 (28)* | 1 | MO |
| *microgestin fe 1/20 (28)* | 1 | MO |
| *mili* | 1 | MO |
| *nikki (28)* | 1 | MO |
| *norethindrone ac-eth estradiol oral tablet 1-20 mg-mcg* | 1 | MO |
| *norgestimate-ethinyl estradiol oral tablet 0.18/0.215/0.25 mg-25 mcg, 0.25-35 mg-mcg* | 1 | |
| *norgestimate-ethinyl estradiol oral tablet 0.18/0.215/0.25 mg-35 mcg (28)* | 1 | MO |
| *nortrel 0.5/35 (28)* | 1 | MO |
| *nortrel 1/35 (21)* | 1 | MO |
| *nortrel 1/35 (28)* | 1 | MO |
| *nortrel 7/7/7 (28)* | 1 | MO |
| *orsythia* | 1 | MO |
| *pimtrea (28)* | 1 | MO |
| *pirmella oral tablet 1-35 mg-mcg* | 1 | MO |
| *portia 28* | 1 | MO |
| *previfem* | 1 | MO |
| *reclipsen (28)* | 1 | MO |
| *setlakin* | 1 | MO |
| *sprintec (28)* | 1 | MO |
| *sronyx* | 1 | MO |
| *syeda* | 1 | MO |
| *tarina 24 fe* | 1 | MO |
| *tarina fe 1-20 eq (28)* | 1 | MO |
| *tilia fe* | 1 | MO |
| *tri-estarylla* | 1 | MO |
| *tri-legest fe* | 1 | MO |
| *tri-lo-estarylla* | 1 | MO |
| *tri-lo-sprintec* | 1 | MO |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *tri-previfem (28)* | 1 | MO |
| *tri-sprintec (28)* | 1 | MO |
| *trivora (28)* | 1 | MO |
| *velivet triphasic regimen (28)* | 1 | MO |
| *vestura (28)* | 1 | |
| *vienva* | 1 | MO |
| *zarah* | 1 | MO |
| *zovia 1-35 (28)* | 1 | |
| **OPHTHALMOLOGY** | | |
| **ANTIBIOTICS** | | |
| AZASITE | 2 | MO |
| *bacitracin ophthalmic (eye)* | 1 | MO |
| *bacitracin-polymyxin b ophthalmic (eye)* | 1 | MO |
| BESIVANCE | 2 | MO |
| *ciprofloxacin hcl ophthalmic (eye)* | 1 | MO |
| *erythromycin ophthalmic (eye)* | 1 | MO; QL (3.5 per 14 days) |
| *gatifloxacin* | 1 | MO |
| *gentak ophthalmic (eye) ointment* | 1 | MO; QL (3.5 per 30 days) |
| *gentamicin ophthalmic (eye) drops* | 1 | MO; QL (70 per 30 days) |
| *levofloxacin ophthalmic (eye)* | 1 | MO |
| *moxifloxacin ophthalmic (eye) drops* | 1 | MO |
| NATACYN | 3 | |
| *neomycin-bacitracin-polymyxin* | 1 | MO |
| *neomycin-polymyxin-gramicidin* | 1 | MO |
| *ofloxacin ophthalmic (eye)* | 1 | MO |
| *polymyxin b sulf-trimethoprim* | 1 | MO |
| *tobramycin ophthalmic (eye)* | 1 | MO; QL (10 per 14 days) |
| **ANTIVIRALS** | | |
| *trifluridine* | 1 | MO |
| ZIRGAN | 3 | MO |
| **BETA-BLOCKERS** | | |
| *betaxolol ophthalmic (eye)* | 1 | MO |
| *carteolol* | 1 | MO |
| *levobunolol ophthalmic (eye) drops 0.5 %* | 1 | MO |
| *timolol maleate ophthalmic (eye) drops* | 1 | MO |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *timolol maleate ophthalmic (eye) gel forming solution* | 1 | MO |
| **MISCELLANEOUS OPHTHALMOLOGICS** | | |
| *atropine ophthalmic (eye) drops* | 1 | MO |
| *azelastine ophthalmic (eye)* | 1 | MO |
| *bepotastine besilate* | 1 | MO |
| BLEPHAMIDE | 3 | MO |
| BLEPHAMIDE S.O.P. | 3 | MO |
| *cromolyn ophthalmic (eye)* | 1 | MO |
| CYSTARAN | 4 | PA |
| *epinastine* | 1 | MO |
| *olopatadine ophthalmic (eye)* | 1 | MO |
| OXERVATE | 4 | PA; MO |
| *pilocarpine hcl ophthalmic (eye) drops 1%, 2%, 4%* | 1 | MO |
| RESTASIS | 2 | MO; QL (60 per 30 days) |
| RESTASIS MULTIDOSE | 2 | MO; QL (5.5 per 30 days) |
| *sulfacetamide sodium ophthalmic (eye)* | 1 | MO |
| *sulfacetamide-prednisolone* | 1 | MO |
| **NON-STEROIDAL ANTI-INFLAMMATORY AGENTS** | | |
| *bromfenac* | 1 | MO |
| BROMSITE | 2 | MO |
| *diclofenac sodium ophthalmic (eye)* | 1 | MO |
| *flurbiprofen sodium* | 1 | MO |
| *ketorolac ophthalmic (eye)* | 1 | MO |
| PROLENSA | 2 | MO |
| **ORAL DRUGS FOR GLAUCOMA** | | |
| *acetazolamide* | 1 | MO |
| *methazolamide* | 1 | MO |
| **OTHER GLAUCOMA DRUGS** | | |
| COMBIGAN | 2 | MO |
| *dorzolamide* | 1 | MO |
| *dorzolamide-timolol* | 1 | MO |
| *latanoprost* | 1 | MO |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| LUMIGAN OPHTHALMIC (EYE) DROPS 0.01 % | 2 | MO |
| RHOPRESSA | 2 | MO |
| ROCKLATAN | 2 | MO |
| SIMBRINZA | 3 | MO |
| *travoprost* | 1 | MO |
| **STEROID-ANTIBIOTIC COMBINATIONS** | | |
| *neomycin-bacitracin-poly-hc* | 1 | MO |
| *neomycin-polymyxin b-dexameth* | 1 | MO |
| *neomycin-polymyxin-hc ophthalmic (eye)* | 1 | MO |
| TOBRADEX OPHTHALMIC (EYE) OINTMENT | 2 | MO; QL (3.5 per 14 days) |
| *tobramycin-dexamethasone* | 1 | MO; QL (10 per 14 days) |
| **STEROIDS** | | |
| ALREX | 2 | MO |
| *dexamethasone sodium phosphate ophthalmic (eye)* | 1 | MO |
| EYSUVIS | 2 | PA; MO; QL (8.3 per 14 days) |
| *fluorometholone* | 1 | MO |
| INVELTYS | 2 | MO |
| *loteprednol etabonate* | 1 | MO |
| *prednisolone acetate* | 1 | MO |
| *prednisolone sodium phosphate ophthalmic (eye)* | 1 | MO |
| **SYMPATHOMIMETICS** | | |
| ALPHAGAN P OPHTHALMIC (EYE) DROPS 0.1 % | 2 | MO |
| *apraclonidine* | 1 | MO |
| *brimonidine ophthalmic (eye) drops 0.15 %* | 1 | |
| *brimonidine ophthalmic (eye) drops 0.2 %* | 1 | MO |
| IOPIDINE OPHTHALMIC (EYE) DROPPERETTE | 3 | MO |

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|---|---|---|
| **RESPIRATORY AND ALLERGY** | | |
| **ANTIHISTAMINE / ANTIALLERGENIC AGENTS** | | |
| *cetirizine oral solution 1 mg/ml* | 1 | MO |
| *epinephrine injection auto-injector 0.15 mg/0.3 ml, 0.3 mg/0.3 ml (manufactured by mylan specialty)* | 1 | MO; QL (2 per 30 days) |
| *hydroxyzine hcl oral tablet* | 1 | PA; MO |
| *levocetirizine oral solution* | 1 | MO |
| *levocetirizine oral tablet* | 1 | MO; QL (30 per 30 days) |
| *promethazine oral* | 1 | PA; MO |
| SYMJEPI | 3 | MO; QL (2 per 30 days) |
| **PULMONARY AGENTS** | | |
| *acetylcysteine* | 1 | PA; MO |
| ADEMPAS | 4 | PA; MO; LA |
| ADVAIR DISKUS | 2 | MO; QL (60 per 30 days) |
| ADVAIR HFA | 2 | MO; QL (12 per 30 days) |
| *albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation* | 1 | QL (17 per 30 days) |
| *albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation package size 6.7 gm* | 1 | QL (13.4 per 30 days) |
| *albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 2.5 mg/0.5 ml* | 1 | PA; MO |
| *albuterol sulfate oral syrup* | 1 | MO |
| *albuterol sulfate oral tablet* | 1 | MO |
| ALVESCO INHALATION HFA AEROSOL INHALER 160 MCG/ACTUATION | 2 | MO; QL (12.2 per 30 days) |
| ALVESCO INHALATION HFA AEROSOL INHALER 80 MCG/ACTUATION | 2 | MO; QL (6.1 per 30 days) |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *alyq* | 4 | PA; QL (60 per 30 days) |
| *ambrisentan* | 4 | PA; MO; LA |
| ARNUITY ELLIPTA | 2 | MO; QL (30 per 30 days) |
| ASMANEX HFA | 2 | MO; QL (13 per 30 days) |
| ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (60) | 2 | MO; QL (1 per 30 days) |
| ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 220 MCG/ ACTUATION (120) | 2 | MO; QL (2 per 30 days) |
| ATROVENT HFA | 2 | MO; QL (25.8 per 30 days) |
| *bosentan* | 4 | PA; MO; LA |
| BREO ELLIPTA | 2 | MO; QL (60 per 30 days) |
| BREZTRI AEROSPHERE | 2 | MO; QL (10.7 per 30 days) |
| *budesonide inhalation suspension for nebulization 0.25 mg/2 ml, 0.5 mg/2 ml* | 1 | PA; MO; QL (120 per 30 days) |
| *budesonide inhalation suspension for nebulization 1 mg/2 ml* | 1 | PA; MO; QL (60 per 30 days) |
| CINRYZE | 4 | PA; MO |
| COMBIVENT RESPIMAT | 2 | MO; QL (8 per 30 days) |
| *cromolyn inhalation* | 4 | PA; MO |
| DALIRESP | 3 | PA; MO; QL (30 per 30 days) |
| DULERA | 2 | MO; QL (13 per 30 days) |
| ESBRIET ORAL CAPSULE | 4 | PA; MO; QL (270 per 30 days) |
| ESBRIET ORAL TABLET 267 MG | 4 | PA; MO; QL (270 per 30 days) |

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|---|---|---|
| ESBRIET ORAL TABLET 801 MG | 4 | PA; MO; QL (90 per 30 days) |
| FASENRA | 4 | PA; MO; QL (1 per 28 days) |
| FASENRA PEN | 4 | PA; MO; QL (1 per 28 days) |
| FLOVENT DISKUS INHALATION BLISTER WITH DEVICE 100 MCG/ACTUATION, 50 MCG/ACTUATION | 2 | MO; QL (60 per 30 days) |
| FLOVENT DISKUS INHALATION BLISTER WITH DEVICE 250 MCG/ACTUATION | 2 | MO; QL (240 per 30 days) |
| FLOVENT HFA AEROSOL INHALER 110 MCG/ACTUATION | 2 | MO; QL (12 per 30 days) |
| FLOVENT HFA AEROSOL INHALER 220 MCG/ACTUATION | 2 | MO; QL (24 per 30 days) |
| FLOVENT HFA AEROSOL INHALER 44 MCG/ACTUATION | 2 | MO; QL (10.6 per 30 days) |
| *flunisolide* | 1 | MO; QL (50 per 30 days) |
| *fluticasone propionate nasal* | 1 | MO; QL (16 per 30 days) |
| *icatibant* | 4 | PA; MO |
| *ipratropium bromide inhalation* | 1 | PA; MO |
| *ipratropium-albuterol* | 1 | PA; MO |
| KALYDECO ORAL GRANULES IN PACKET | 4 | PA; MO; QL (56 per 28 days) |
| KALYDECO ORAL TABLET | 4 | PA; MO; QL (60 per 30 days) |
| *levalbuterol hcl* | 1 | PA; MO |
| *mometasone nasal* | 1 | MO; QL (34 per 30 days) |
| *montelukast* | 1 | MO |
| NUCALA | 4 | PA; MO; LA; QL (3 per 28 days) |
| OFEV | 4 | PA; MO; QL (60 per 30 days) |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| OPSUMIT | 4 | PA; MO; LA |
| ORKAMBI ORAL GRANULES IN PACKET | 4 | PA; MO; QL (56 per 28 days) |
| ORKAMBI ORAL TABLET | 4 | PA; MO; QL (112 per 28 days) |
| ORLADEYO | 4 | PA; LA |
| PERFOROMIST | 2 | PA; MO |
| PULMICORT FLEXHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 180 MCG/ACTUATION | 2 | MO; QL (2 per 30 days) |
| PULMICORT FLEXHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 90 MCG/ACTUATION | 2 | MO; QL (1 per 30 days) |
| PULMOZYME | 4 | PA; MO |
| QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 40 MCG/ACTUATION | 2 | MO; QL (10.6 per 30 days) |
| QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 80 MCG/ACTUATION | 2 | MO; QL (21.2 per 30 days) |
| *sildenafil (pulmonary arterial hypertension) oral tablet* | 1 | PA; MO; QL (90 per 30 days) |
| SPIRIVA RESPIMAT | 2 | MO; QL (4 per 30 days) |
| SPIRIVA WITH HANDIHALER | 2 | MO; QL (90 per 90 days) |
| STIOLTO RESPIMAT | 2 | MO; QL (4 per 30 days) |
| STRIVERDI RESPIMAT | 2 | MO; QL (4 per 30 days) |
| SYMBICORT | 2 | MO; QL (10.2 per 30 days) |
| SYMDEKO | 4 | PA; MO; QL (56 per 28 days) |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *tadalafil (pulmonary arterial hypertension) oral tablet 20 mg* | 4 | PA; QL (60 per 30 days) |
| *terbutaline oral* | 1 | MO |
| THEO-24 | 2 | MO |
| *theophylline oral solution* | 1 | MO |
| *theophylline oral tablet extended release 12 hr 300 mg* | 1 | MO |
| *theophylline oral tablet extended release 24 hr* | 1 | MO |
| TRELEGY ELLIPTA | 2 | MO; QL (60 per 30 days) |
| TRIKAFTA ORAL TABLETS, SEQUENTIAL 100-50-75 MG(D) /150 MG (N) | 4 | PA; MO; QL (84 per 28 days) |
| XOLAIR SUBCUTANEOUS RECON SOLN | 4 | PA; MO; LA; QL (8 per 28 days) |
| XOLAIR SUBCUTANEOUS SYRINGE 150 MG/ML | 4 | PA; MO; LA; QL (8 per 28 days) |
| XOLAIR SUBCUTANEOUS SYRINGE 75 MG/0.5 ML | 4 | PA; MO; LA; QL (1 per 28 days) |
| *zafirlukast* | 1 | MO |
| ZYFLO | 4 | MO |

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **UROLOGICALS** | | |
| **ANTICHOLINERGICS / ANTISPASMODICS** | | |
| *flavoxate* | 1 | MO |
| MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HR | 2 | MO |
| *oxybutynin chloride* | 1 | MO |
| *tolterodine* | 1 | MO |
| TOVIAZ | 2 | MO |
| *trospium oral tablet* | 1 | MO |
| **BENIGN PROSTATIC HYPERPLASIA( BPH) THERAPY** | | |
| *alfuzosin* | 1 | MO |
| *dutasteride* | 1 | MO |
| *dutasteride-tamsulosin* | 1 | MO |
| *finasteride oral tablet 5 mg* | 1 | MO |
| *silodosin* | 1 | MO |
| *tamsulosin* | 1 | MO |
| **MISCELLANEOUS UROLOGICALS** | | |
| *bethanechol chloride* | 1 | MO |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| CYSTAGON | 3 | PA; LA |
| ELMIRON | 2 | MO |
| *potassium citrate* | 1 | MO |
| **VITAMINS, HEMATINICS / ELECTROLYTES** | | |
| **ELECTROLYTES** | | |
| *calcium acetate(phosphat bind)* | 1 | MO; QL (360 per 30 days) |
| *klor-con 10* | 1 | MO |
| *klor-con 8* | 1 | MO |
| *klor-con m10* | 1 | MO |
| *klor-con m15* | 1 | MO |
| *klor-con m20* | 1 | MO |
| *klor-con oral packet 20* | 1 | MO |
| *k-tab oral tablet extended release 8 meq* | 1 | MO |
| *magnesium sulfate injection solution* | 1 | MO |
| *magnesium sulfate injection syringe* | 1 | |
| *potassium chlorid-d5-0.45%nacl* | 1 | |
| *potassium chloride in 0.9%nacl intravenous parenteral solution 20 meq/l, 40 meq/l* | 1 | |
| *potassium chloride in 5 % dex intravenous parenteral solution 20 meq/l* | 1 | |
| *potassium chloride in lr-d5 intravenous parenteral solution 20 meq/l* | 1 | |
| *potassium chloride in water intravenous piggyback 10 meq/100 ml, 20 meq/100 ml, 40 meq/100 ml* | 1 | |
| *potassium chloride intravenous* | 1 | |
| *potassium chloride oral capsule, extended release* | 1 | MO |
| *potassium chloride oral liquid* | 1 | MO |
| *potassium chloride oral packet* | 1 | |
| *potassium chloride oral tablet extended release 10 meq, 8 meq* | 1 | MO |

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| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *potassium chloride oral tablet extended release 20 meq* | 1 | |
| *potassium chloride oral tablet,er particles/crystals 10 meq* | 1 | MO |
| *potassium chloride oral tablet,er particles/crystals 20 meq* | 1 | |
| *potassium chloride-0.45 % nacl* | 1 | |
| *potassium chloride-d5-0.2%nacl intravenous parenteral solution 20 meq/l* | 1 | |
| *potassium chloride-d5-0.9%nacl* | 1 | |
| *sodium chloride 0.45 % intravenous parenteral solution* | 1 | MO |
| *sodium chloride 3 %* | 1 | |
| *sodium chloride 5 %* | 1 | MO |
| **MISCELLANEOUS NUTRITION PRODUCTS** | | |
| AMINOSYN II 15 % | 3 | PA |
| AMINOSYN-PF 7 % (SULFITE-FREE) | 3 | PA |
| CLINIMIX 5%/D15W SULFITE FREE | 3 | PA |
| CLINIMIX 4.25%/D10W SULF FREE | 3 | PA |
| CLINIMIX 5%-D20W(SULFITE-FREE) | 3 | PA |
| HEPATAMINE 8% | 2 | PA |
| *intralipid intravenous emulsion 20 %* | 1 | PA |
| ISOLYTE S PH 7.4 | 3 | |
| ISOLYTE-P IN 5 % DEXTROSE | 3 | |
| PLASMA-LYTE 148 | 2 | |
| PLASMA-LYTE A | 2 | |
| PLENAMINE | 3 | PA |
| *premasol 10 %* | 1 | PA |
| *travasol 10 %* | 1 | PA |
| TROPHAMINE 10 % | 3 | PA |
| **VITAMINS / HEMATINICS** | | |
| *fluoride (sodium) oral tablet* | 1 | |
| *prenatal vitamin oral tablet* | 1 | |

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You must use network pharmacies to fill your prescriptions to get the most out of your benefit. However, there are emergency circumstances under which you may be reimbursed for a covered prescription that is not filled at a network pharmacy. Limitations, copayments and restrictions may apply.

This formulary was updated on 08/24/2021. For more recent information or to price a medication, you can visit us on the Web at **express-scripts.com**. Or you can contact **Express Scripts Medicare®** (PDP) Customer Service at the numbers located on the back of your member ID card. Customer Service is available 24 hours a day, 7 days a week.



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