



Contra Costa Health Plan (CCHP) Basic Healthcare Formulary

Last Updated: March 1, 2026

Note: The CCHP formulary is subject to change, and all previous versions are no longer in effect.

- To access the electronic version of the CCHP formulary on the health plan's website, please go to the following web address: <https://cchealth.org/healthplan/pdf/pdf.pdf>
- To access the CCHP interactive formulary search tool, please go to the following web address: <https://formularynavigator.com/Search.aspx?siteID=MMRREQ3QBC>
- To access plan-specific coverage information including cost sharing information, member handbook, and other important materials such as your Evidence of Coverage (EOC) documents, please go to the following web address: <https://cchealth.org/healthplan/member-publications.php>

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Frequently Asked Questions

What is the CCHP formulary?

The CCHP formulary (also known as the CCHP preferred drug list, or PDL) includes drugs used to treat common diseases or health problems. This formulary applies only to outpatient drugs and self-administered drugs – it does not apply to medications used in the inpatient setting or in medical offices.

The formulary is a continually reviewed and revised list of preferred medications based on safety, efficacy, and cost-effectiveness. It is updated on a monthly basis and is effective the first of every month. Updates are based on input from a team of doctors and pharmacists that meet regularly to decide which drugs should be included. These updates may include, but are not limited to the following: (i) removal or addition of drugs and/or dosage forms. (ii) changes in tier placement of a drug (iii) changes to utilization management restrictions (such as quantity limits, step therapy, etc.). Updated documents are available online at: <https://www.cchealth.org>.

How do I use the CCHP formulary?

The list of formulary drugs begins on Page 1. To locate a drug on the formulary, simply look for the name of the drug in the index at the end of this booklet - the index lists all of the drugs on the formulary, including brand name and generic name. Once you have located the name of the drug in the index, you will see the page number where you can find more information about your drug listed next to it.

Instead of using the index, the formulary can also be searched by using ctrl+F to find a specific medication by brand name, generic name, or therapeutic class.

A mobile-enabled version of the CCHP formulary is also available using the ePocrates application. After you have downloaded the application to your mobile device, simply choose the “Contra Costa Health Plan-Commercial” formulary to display the formulary status of drugs within the application. If you have any questions about the installation or use of the Epocrates application, please contact Epocrates Customer Support at (800)230-2150 or goldsupport@epocrates.com.








The presence of a prescription drug on the CCHP formulary does not guarantee that a member will be prescribed that medication by his or her prescribing provider for a particular medical condition. The absence of a drug on the CCHP means that the drug

is not on the formulary, and will require prior authorization to be covered (specific information about the CCHP prior authorization process is located below in the section titled “What if the drug that I need isn’t listed on the CCHP formulary?”)

How are drugs listed on the formulary?

Drugs are listed alphabetically by brand and generic name within the therapeutic category and class to which they belong. Brand name drugs will appear in all CAPITAL letters, with the generic name listed in parentheses after the brand name in all ***bold and italicized lowercase letters***. If a generic drug is available, it will be listed separately from the brand name drug, and will always be listed in ***bold and italicized lowercase letters***. If a generic equivalent of a brand name drug is not available, then the generic drug will not be listed separately from the brand name drug. In situations where an FDA approved generic equivalent is available, brand names are listed for reference purposes only, and do not denote coverage for the brand, unless specifically noted.

An example listing from the CCHP formulary is below:

Therapeutic Class			Drug Tier		
					
Insulins - Drugs For Diabetes					
LANTUS SOLOSTAR U-100 INSULIN		(<i>insulin glargine</i>)		T2	QL (30mL per 30 days)
					
Brand Name		Generic Name		Coverage Limits	

What if the drug that I need isn’t listed on the CCHP formulary?

If your drug isn’t listed on the CCHP formulary you can ask your doctor if there is a different drug on the formulary that will work the same way. If your doctor decides that you need a drug that is not on the formulary, they can ask CCHP to make an exception through the prior authorization process. All prior authorization requests will be evaluated by a health plan clinician (pharmacist or medical doctor) based upon CCHP prior authorization criteria that is approved by the CCHP Pharmacy and Therapeutics (P&T) committee. In instances where specific criteria do not exist, FDA indications, peer reviewed literature, other plan criteria, national treatment guidelines (such as IDSA, NCCN, AACE, etc.), and other medical compendia will be used for evaluation. Exceptions can be made for a variety of different reasons:

- Your doctor can ask CCHP to cover a drug that is listed on the formulary as requiring a prior authorization (PA): these drugs require approval prior to being dispensed at a network pharmacy. Each request will be reviewed by a health plan clinician, and if the request does not meet the guidelines established by the plan it will not be approved, and alternative therapy may be recommended.

- Your doctor can ask CCHP to cover a drug that isn't listed on the formulary: any drug not found on this list is considered non-formulary. Coverage for non-formulary agents may be requested by the prescriber. Each request will be reviewed by a health plan clinician, and approval will be given if a documented medical need exists and if there isn't an alternate agent on the formulary.
- Your doctor can ask CCHP to make an exception to limits on a drug. For example, if a drug has a limit of 1 tablet per day, your doctor can ask us to cover more. If quantities exceeding the limit are necessary, an exception to coverage may be requested by the prescriber. Each request will be reviewed by a health plan clinician, and approval will be given if a documented medical need exists without compromising safety.
- Your doctor can ask CCHP to make an exception to Step Therapy (ST) requirements: these drugs require one or more first step drugs to be tried before progressing to the second step drug (for example, if Drug A and Drug B both treat your health condition, CCHP may not cover Drug B unless you try Drug A first). If there is a medical need to use a second step drug without trying a first step drug, an exception to coverage may be requested by the prescriber. Each request will be reviewed by a health plan clinician, and approval will be given if a documented medical need exists. If you have already tried and failed the preferred drug(s), or if you are already taking a drug that is subject to step therapy when you switch to CCHP, you will not have to try the preferred drugs again. Your doctor can simply request an approval through the plan for continuation of therapy.

To start the CCHP prior authorization process or to ask for an exception, your doctor must fax a prior authorization request to CCHP at **1-866-428-7369** for urgent requests, or **1-866-205-8014** for standard requests. Your doctor may also be able to submit the request electronically to CCHP using the electronic medical record. If the request is approved, you will be able to get your medication filled at a pharmacy that works with CCHP. If we deny the request we will send you and your doctor a letter and will tell you how to file an appeal or a grievance. An "appeal" is when you want a decision to be reviewed again by the health plan (usually with additional information), and a "grievance" is a complaint or concern regarding the health plan.

CCHP will make a decision to deny or approve all prior authorization and exception requests within 24 hours of receiving the request. If CCHP fails to respond to a prior authorization or step therapy request within 72 hours of receiving a non-urgent request or 24 hours of receiving a request based on exigent circumstances, the request shall be deemed approved.

CCHP will provide coverage pursuant to a non-urgent request for the duration of the prescription, including refills. CCHP will provide coverage, including refills, pursuant to a request based on exigent circumstances for the duration of the exigency.

If you would like to download the CCHP prior authorization form, it is available at: https://cchealth.org/healthplan/pdf/performrx_medication_prior_auth_form.pdf

What if I need my medication urgently – do pharmacies have the ability to fill emergency supplies of medication?

Yes. To ensure that CCHP members have access to a sufficient supply of medications in emergency situations, CCHP has established an Emergency Supply Policy that allows pharmacists to use their clinical judgement to override claims that deny at the point of sale. When a pharmacist determines that a medication is medically necessary, they may enter an authorization code that allows them to fill a 5-day emergency supply of medication for any CCHP member. CCHP promotes the use of the Emergency Supply Policy through point-of-sale messaging.

Instead of using the 5-day Emergency Supply Policy, pharmacies may also choose to call the PerformRx provider call center at 877-234-4269 – representatives are available 24 hours per day, 365 days per year. Staff at the call center have the ability to override prescriptions based on guidance provided by CCHP.

What if I'm a new CCHP member?

If you are a new CCHP member you may be taking drugs that are not on our formulary, or you may be taking drugs that are on our formulary but have limits. If possible, you should talk to your doctor to see if you can change to a preferred drug on the CCHP formulary. If you cannot switch to a preferred drug, then your doctor will need to ask CCHP for an exception to cover a drug you have been taking (known as continuation of therapy). See the section above titled “What if the drug that I need isn’t listed on the CCHP formulary?” for more information.

Does CCHP cover generic and brand name medications?

CCHP covers brand and generic drugs, but when a generic drug is available CCHP requires that it be used. All drugs that become available generically are subject to review by the CCHP Pharmacy & Therapeutics committee.

A prescriber may request a brand name product in lieu of an approved generic if the prescriber determines that there is a documented medical need for the brand equivalent. This type of request for coverage may be made through the CCHP prior authorization process described above in the section titled “What if the drug that I need isn’t listed on the CCHP formulary.”

Are there drugs that are excluded from coverage?

For the CCHP Basic Healthcare pharmacy benefit, there are no prescription medications that are excluded for coverage. Your doctor can ask CCHP to cover a drug that isn’t listed on the formulary: any drug not found on this list is considered non-formulary. Coverage for non-formulary agents may be requested by the prescriber. Each request will be reviewed by a health plan clinician, and approval will be given if a documented medical need exists and if there isn’t an alternate agent on the formulary.

If CCHP's coverage is amended to exclude a drug that we have been covering and providing to you under your current coverage, we will continue to provide the drug if a plan physician continues to prescribe the drug for the same condition and for a use approved by the Food and Drug Administration.

Can I go to any pharmacy for my medication?

No, members must use a pharmacy that is in the CCHP network. To find a network pharmacy, visit the CCHP website or call the health plan directly to have one of our member services or pharmacy staff help you locate a pharmacy near you (see section below titled "How do I find a pharmacy?").

How do I find a pharmacy?

To find a pharmacy near you, visit the CCHP website at <https://cchealth.org/healthplan/>. Once you have navigated to the CCHP website, follow the directions below:

- (1) Scroll down and click on the "Search Doctors/Clinics/Pharmacies in My Area" button
- (2) Click on the red "Begin Your Search Here" button (a new window will pop up)
- (3) Click on the "Facility" tab, and choose "Pharmacy" as the facility type
- (4) Choose how you want to search (by zip code, distance, etc.)
- (5) Click "Find a Facility" - results will immediately show up (as a map and a list)

Be sure to show your CCHP Member ID card when you fill your prescriptions at the pharmacy.

Note: some medications are subject to limited distribution by the U.S. Food and Drug Administration. These types of drugs are called "specialty medications" because they require special handling, provider coordination, or special education that may not be

provided at your local pharmacy. CCHP has a contract with Walgreens to provide these types of medications. If you have specific questions about these types of drugs please contact the CCHP pharmacy unit directly.

What drugs are covered by CCHP?

You can get the following drugs and other items when they are prescribed by your doctor and are medically necessary:

- Prescription drugs listed on the CCHP formulary
- Non-prescription drugs or over-the-counter drugs (such as cough/cold syrups, cough drops or aspirin) listed on the CCHP formulary
- Formulary diabetic supplies: insulin, insulin syringes, glucose test strips, lancets and lancet puncture devices, pen delivery systems, and blood glucose monitors
- FDA-approved birth control and contraceptives listed on the CCHP formulary
- Emergency contraception
- Epi-Pens, peak flow meters and spacers

Are intravenous (IV) and injectable drugs covered by CCHP?

Yes, the CCHP formulary lists certain injectable products that are covered as a pharmacy benefit. CCHP also covers most other intravenous medications through the medical benefit. Medications that are generally covered through the medical benefit are those that are given in a doctor's office, clinic, or hospital setting. Requests for coverage of a medication through the medical benefit should be directed to the CCHP Utilization Management Department by downloading the medical referral form at <https://cchealth.org/healthplan/providers/> and faxing to (925) 313-6058 for routine requests or (925) 313-6458 for urgent requests.

Coverage of intravenous and injectable drugs through the pharmacy benefit are outlined below:

- **Simple intravenous solutions:** simple intravenous solutions are typically used for hydration therapy. Included are commercially available (non-compounded) solutions such as Normal Saline, Dextrose (up to 10% in Water) and Lactated Ringer's Solution; commercially prepared solutions of potassium chloride in such solutions are also included in this definition. Simple intravenous solutions should be billed using the product's National Drug Code (NDC) number.
- **Parenteral nutrition solutions (TPN or hyperalimentation):** restricted to dispensing within 10 days following inpatient discharge from an acute care hospital, when (IV) therapy with the same product was started before discharge. There is a maximum of 10 days supply per dispensing within this 10-day period. (Parenteral nutrition solutions are intravenously or intra-arterially administered nutritional products that typically are suspensions or solutions of amino acids or protein, dextrose, lipids, electrolytes, vitamin &/or mineral supplements and trace elements.) Adjuncts to

parenteral nutrition are other drugs which are physically mixed into a parenteral nutrition solution at any time prior to administration. Bill for these products as part of the parenteral nutrition billing. **Note:** Non-compounded products must be billed using the product's NDC number. Compounded solutions must be billed as a compound claim.

- Separately administered intravenous lipids: restricted to dispensing within 10 days following inpatient discharge from an acute care hospital, when (IV) therapy with the same product was started before discharge. There is a maximum of 10 days supply per dispensing within this 10-day period. Intravenous lipid solutions or suspensions that are administered separately from parenteral nutrition solutions (that is, are not physically mixed into the parenteral nutrition solution container) should be billed using the product's NDC number.
- Intravenous solutions of unlisted antibiotics: restricted to dispensing within 10 days following inpatient discharge from an acute care hospital, when IV therapy with the same antibiotic was started before discharge. There is a maximum of 10 days supply per dispensing within the 10-day period. **Note:** Non-compounded products must be billed using the product's NDC number. Compounded solutions must be billed as a compound claim.
- Intravenous solutions of other unlisted drugs: restricted to dispensing within 10 days following inpatient discharge from an acute care hospital, when IV therapy with the same drug was started before discharge. There is a maximum of 10 days supply per dispensing within the 10-day period. **Note:** Non-compounded products must be billed using the product's NDC number. Compounded solutions must be billed as a compound claim.

How Much I Will Pay for My Drugs?

For all CCHP BHC members, you do not have to pay for covered services; medications are available with no copay.

Can providers make suggestions to CCHP to improve the formulary?

Absolutely. The formulary is a tool to promote cost-effective prescription drug use. CCHP has made every attempt to create a document that meets all therapeutic needs, however the art of medicine makes this a formidable task. CCHP welcomes the participation of physicians, pharmacists, and ancillary medical providers in this dynamic process. Physicians and pharmacists are highly encouraged to direct any suggestions or comments to CCHP via e-mail at: cchp_pharmacy_director@hsd.cccounty.us.

What if I need more information?

For more information about your pharmacy benefits, please review your Evidence of Coverage documents or call CCHP directly to discuss. CCHP member services department and pharmacy department staff are available to answer questions Monday through Friday from 8:00am to 5:00pm Pacific Time at the phone numbers listed below:

CCHP Member Services Department: **(877) 661-6230 x2**

CCHP Pharmacy Department: **(877) 661-6230 x3**

Definitions & Abbreviations:

There are a number of terms that are used in this document that Contra Costa Health Plan wants to make sure that you understand. Below are some definitions and abbreviations:

“Brand name drug” is a drug that is marketed under a proprietary, trademark protected name. The brand name drug is listed in all CAPITAL letters.

“Coinsurance” is a percentage of the cost of a covered health care benefit that an enrollee pays after the enrollee has paid the deductible, if a deductible applies to the health care benefit, such as the prescription drug benefit.

“Copayment” is a fixed dollar amount that an enrollee pays for a covered health care benefit after the enrollee has paid the deductible, if a deductible applies to the health care benefit, such as the prescription drug benefit.

“Deductible” is the amount an enrollee pays for covered health care benefits before the enrollee's health plan begins payment for all or part of the cost of the health care benefit under the terms of the policy.

“Drug Tier” is a group of prescription drugs that corresponds to a specified cost sharing tier in the health plan's prescription drug coverage. The tier in which a prescription drug is placed determines the enrollee's portion of the cost for the drug.

“Enrollee” is a person enrolled in a health plan who is entitled to receive services from the plan. All references to enrollees in this formulary template shall also include subscribers as defined in this section below.

“Exception request” is a request for coverage of a prescription drug. If an enrollee, his or her designee, or prescribing healthcare provider submits an exception request for coverage of a prescription drug, the health plan must cover the prescription drug when the drug is determined to be medically necessary to treat the enrollee's condition.

“Exigent circumstances” are when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function, or when an enrollee is undergoing a current course of treatment using a non-formulary drug.

“Formulary” is the complete list of drugs preferred for use and eligible for coverage under a health plan product, and includes all drugs covered under the outpatient prescription drug benefit of the health plan product. Formulary is also known as a prescription drug list,

“Generic drug” is the same drug as its brand name equivalent in dosage, safety, strength, how it is taken, quality, performance, and intended use. A generic drug is listed in ***bold and italicized lowercase*** letters.

“Nonformulary drug” is a prescription drug that is not listed on the health plan's formulary.

“Out-of-pocket cost” are copayments, coinsurance, and the applicable deductible, plus all costs for health care services that are not covered by the health plan.

“Prescribing provider” is a health care provider authorized to write a prescription to treat a medical condition for a health plan enrollee.

“Prescription” is an oral, written, or electronic order by a prescribing provider for a specific enrollee that contains the name of the prescription drug, the quantity of the prescribed drug, the date of issue, the name and contact information of the prescribing provider, the signature of the prescribing provider if the prescription is in writing, and if requested by the enrollee, the medical condition or purpose for which the drug is being prescribed.

“Prescription drug” is a drug that is prescribed by the enrollee's prescribing provider and requires a prescription under applicable law.

“Prior Authorization” is a health plan's requirement that the enrollee or the enrollee's prescribing provider obtain the health plan's authorization for a prescription drug before the health plan will cover the drug. The health plan shall grant a prior authorization when it is medically necessary for the enrollee to obtain the drug.

“Step therapy” is a process specifying the sequence in which different prescription drugs for a given medical condition and medically appropriate for a particular patient are prescribed. The health plan may require the enrollee to try one or more drugs to treat the enrollee's medical condition before the health plan will cover a particular drug for the condition pursuant to a step therapy request. If the enrollee's prescribing provider submits a request for step therapy exception, the health plans shall make exceptions to step therapy when the criteria is met.

“Subscriber” means the person who is responsible for payment to a plan or whose employment or other status, except for family dependency, is the basis for eligibility for membership in the plan.

Additional abbreviations and terms used on the CCHP formulary document are explained below:

Abbreviation	Term	What it means
AL	Age Limit	Some drugs are only covered for certain ages.
NF	Non-Formulary	These drugs are not covered on the Drug List. If your doctor feels you need a drug that is not covered, he or she can ask us to make an exception.
PA	Prior Authorization	Your doctor must ask for approval from CCHP before some drugs will be covered.
QL	Quantity Limit	Some drugs are only covered for a certain amount.
SCO	State Carve-Out	These drugs are carved out by the Department of Health Care Services. This means these drugs are covered by the Medi-Cal Fee-for-Service program and must be billed to the State by the pharmacy.
ST	Step Therapy	In some cases, you must first try certain drugs before CalViva Health covers another drug for your medical condition. For example, if Drug A and Drug B both treat your health condition, CCHP may not cover Drug B unless you try Drug A first.

The CCHP formulary uses a 3 tier structure – the tiers are explained below:

Abbreviation	Term	What it means
T1	Tier 1	Tier 1 medications are preferred on the CCHP formulary and are available without restriction or prior authorization.
T2	Tier 2	Tier 2 medications are preferred on the CCHP formulary and are available without prior authorization, BUT may have certain restrictions such as quantity limits, step therapy, etc. (the specific restrictions are listed on the CCHP formulary).
T3	Tier 3	Tier 3 medications are non-preferred. These medications require prior authorization.



Plan de Salud de Contra Costa (CCHP) ORGANIZACIÓN DE ADMINISTRACIÓN DE SALUD "Basic Healthcare" Formulario

Última actualización: 1 de marzo de 2026

Nota: El formulario del CCHP está sujeto a cambios, y todas las versiones anteriores ya no están vigentes.

- Para acceder a la versión electrónica del formulario del CCHP en el sitio web del plan de salud, visite la siguiente dirección web: <https://cchealth.org/healthplan/pdi/pdi.pdf>
- Para acceder a la herramienta de búsqueda del formulario interactivo del CCHP, visite la siguiente dirección web: <https://formularynavigator.com/Search.aspx?siteID=MMRREQ3QBC>
- Para acceder a la información de cobertura específica del plan que incluye información de costos compartidos, manual para miembros y otros materiales importantes como los documentos de su Evidencia de cobertura (EOC), visite la siguiente dirección web:
<https://cchealth.org/healthplan/member-publications.php>

Preguntas frecuentes

¿Qué es el formulario del CCHP?

El formulario del CCHP (también conocido como la lista de medicamentos preferidos del CCHP, o PDL) incluye medicamentos utilizados para tratar enfermedades o problemas de salud comunes. Este formulario aplica solo a los medicamentos para pacientes en consulta externa y medicamentos autoadministrados, no aplica a medicamentos utilizados en el entorno de pacientes internados o en consultorios médicos.

El formulario es una lista de medicamentos preferidos examinada y revisada continuamente en función de la seguridad, eficacia y rentabilidad. Se actualiza mensualmente y es efectiva el primer día de cada mes. Las actualizaciones se basan en comentarios de un grupo de médicos y farmacéuticos que se reúnen regularmente para decidir qué medicamentos deben incluirse. Estas actualizaciones pueden incluir, entre otros, lo siguiente: (i) eliminación o adición de medicamentos o formas farmacéuticas, (ii) cambios en la colocación de nivel de un medicamento, (iii) cambios en las restricciones de administración de utilización (como límites de cantidad, tratamiento escalonado, etc.). Los documentos actualizados están disponibles en línea en: <https://www.cchealth.org>.

¿Cómo uso el formulario del CCHP?

La lista de medicamentos de formulario comienza en la Página 1. Para ubicar un medicamento en el formulario, simplemente busque el nombre del medicamento en el índice al final de este folleto. El índice enumera todos los medicamentos en el formulario, incluidos los medicamentos de marca y los medicamentos genéricos. Una vez que haya ubicado el nombre del medicamento en el índice, verá el número de página en donde puede encontrar más información sobre el medicamento indicado junto a este.

En lugar de usar el índice, también se puede buscar en el formulario usando ctrl+F para encontrar un medicamento específico por marca, nombre genérico o clase terapéutica.

Una versión para teléfonos celulares del formulario del CCHP también está disponible usando la aplicación ePocrates. Después de que haya descargado la aplicación a su dispositivo móvil, simplemente elija el formulario "Plan de Salud de Contra Costa Medical" para mostrar el estado de formulario de los medicamentos en la aplicación. Si tiene alguna pregunta sobre la instalación o uso de la aplicación Epocrates, comuníquese con atención al cliente de Epocrates al (800)230-2150 o goldsupport@epocrates.com.



La presencia de un medicamento que requiere receta en el formulario del CCHP no garantiza que el proveedor que emite recetas le recete a un miembro ese medicamento para una afección médica particular.

Si un medicamento no está en el formulario del CCHP, requerirá una autorización previa para que esté cubierto (la información específica sobre el proceso de autorización previa del CCHP se encuentra a continuación en la sección titulada “¿Qué sucede si el medicamento que necesito no está en el formulario del CCHP?”)

¿Cómo se indican los medicamentos en el formulario?

Los medicamentos están indicados alfabéticamente por marca y nombre genérico en la categoría terapéutica y clase a la que pertenecen. Los medicamentos de marca aparecerán en MAYÚSCULAS, con el nombre genérico indicado en paréntesis después de la marca todo escrito en **letra minúscula negrita y cursiva**. Si el medicamento genérico está disponible, se indicará de forma separada del medicamento de marca y siempre se indicará en **letra minúscula negrita y cursiva**. Si un genérico equivalente de un medicamento de marca no está disponible, el medicamento genérico no estará indicado de forma separada del medicamento de marca. En situaciones en las que un equivalente genérico aprobado por la Administración de Alimentos y Medicamentos (Food & Drug Administration, FDA) está disponible, las marcas se indican con fines de referencia únicamente, y no denotan cobertura para la marca, a menos que se indique específicamente.

Una lista de ejemplo del formulario del CCHP se encuentra a continuación:

Clase terapéutica		Nivel de medicamento	
↓		↓	
Insulins - Drugs For Diabetes			
LANTUS SOLOSTAR U-100 INSULIN (<i>insulin glargine</i>)		T2	QL (30mL per 30 days)
↑	↑	↑	
Marca	Nombre genérico	Limites de cobertura	

¿Qué sucede si el medicamento que necesito no está indicado en el formulario del CCHP?

Si su medicamento no figura en el formulario del CCHP, puede preguntarle a su médico si hay un medicamento diferente en el formulario que funcione de la misma manera. Si su médico decide que necesita un medicamento que no está en el formulario, puede pedirle al CCHP que haga una excepción a través del proceso de autorización previa. Todas las solicitudes de autorización previa serán evaluadas por un médico del plan de salud (farmacéutico o médico) según los criterios de autorización previa del CCHP

aprobados por el comité de Farmacia y Terapéutica (P&T) del CCHP. En los casos en que no existan criterios específicos, se utilizarán para la evaluación indicaciones de la FDA, literatura revisada por pares, otros criterios del plan, pautas nacionales de tratamiento (como IDSA, NCCN, AACE, etc.) y otros compendios médicos. Se pueden hacer excepciones por una variedad de motivos diferentes:

- Su médico puede pedirle al CCHP que cubra un medicamento que figura en el formulario que requiere una autorización previa (PA): estos medicamentos requieren aprobación antes de ser despachados en una farmacia de la red. Cada solicitud será revisada por un médico del plan de salud, y si la solicitud no cumple con las pautas establecidas por el plan, no será aprobada, y se puede recomendar una terapia alternativa.
- Su médico puede pedirle al CCHP que cubra un medicamento que no figura en el formulario: cualquier medicamento que no se encuentre en esta lista se considera no incluido en el formulario. La persona que emite la receta puede solicitar cobertura para agentes que no figuran en el formulario. Cada solicitud será revisada por un médico del plan de salud y se aprobará si existe una necesidad médica documentada y si no hay un agente alternativo en el formulario.
- Su médico puede pedirle al CCHP que haga una excepción a los límites de un medicamento. Por ejemplo, si un medicamento tiene un límite de 1 tableta por día, su médico puede pedirnos que cubramos más. Si se necesitan cantidades que exceden el límite, la persona que emite la receta puede solicitar una excepción a la cobertura. Cada solicitud será revisada por un médico del plan de salud y se aprobará si existe una necesidad médica documentada sin comprometer la seguridad.
- Su médico puede pedirle al CCHP que haga una excepción a los requisitos de tratamiento escalonado (ST): estos medicamentos requieren que se prueben uno o más medicamentos de primer paso antes de pasar al medicamento de segundo paso (por ejemplo, si el medicamento A y el medicamento B tratan su afección de salud, el CCHP puede no cubrir el medicamento B a menos que primero pruebe el medicamento A). Si existe una necesidad médica de usar un medicamento de segundo paso sin probar un medicamento de primer paso, la persona que emite la receta puede solicitar una excepción a la cobertura. Cada solicitud será revisada por un médico del plan de salud y se aprobará si existe una necesidad médica documentada. Si ya probó el medicamento preferido y este falló, o si ya está tomando un medicamento sujeto a tratamiento escalonado cuando se cambia al CCHP, no tendrá que probar los medicamentos preferidos nuevamente. Su médico simplemente puede solicitar una aprobación a través del plan para la continuación del tratamiento.

Para comenzar el proceso de autorización previa del CCHP o para solicitar una excepción, su médico debe enviar por fax una solicitud de autorización previa al CCHP al **1-866-428-7369** para solicitudes urgentes, o **1-866-205-8014** para solicitudes

estándar. Su médico también puede enviar la solicitud electrónicamente al CCHP utilizando la historia clínica electrónica. Si se aprueba la solicitud, podrá surtir su medicamento en una farmacia que trabaje con el CCHP. Si denegamos la solicitud, le enviaremos una carta a usted y a su médico y le diremos cómo presentar una apelación o una queja formal. Una "apelación" es cuando desea que el plan de salud revise nuevamente una decisión (generalmente con información adicional), y una "queja formal" es una queja o inquietud relacionada con el plan de salud.

El CCHP tomará la decisión de denegar o aprobar todas las solicitudes de autorización previa y de excepción dentro de las 24 horas posteriores a la recepción de la solicitud. Si el CCHP no responde a una autorización previa o solicitud de tratamiento escalonado dentro de las 72 horas de haber recibido una solicitud no urgente o 24 horas después de recibir una solicitud basada en circunstancias exigentes, la solicitud se considerará aprobada.

El CCHP proporcionará cobertura de conformidad con una solicitud no urgente por la duración de la receta, incluidos los resurtidos. El CCHP proporcionará cobertura, incluidos los resurtidos, de conformidad con una solicitud basada en circunstancias exigentes por la duración de la exigencia.

Si desea descargar el formulario de autorización previa del CCHP, está disponible en: https://cchealth.org/healthplan/pdf/performrx_medication_prior_auth_form.pdf

¿Qué sucede si necesito mi medicamento con urgencia? ¿Las farmacias tienen la capacidad de surtir suministros de medicamentos de emergencia?

Sí. Para garantizar que los miembros del CCHP tengan acceso a un suministro suficiente de medicamentos en situaciones de emergencia, el CCHP ha establecido una Política de suministros de emergencia que permite a los farmacéuticos utilizar su criterio clínico para anular los reclamos que rechazan en el punto de venta. Cuando un farmacéutico determina que un medicamento es médicamente necesario, puede ingresar un código de autorización que le permita surtir un suministro de medicamentos de emergencia para 5 días para cualquier miembro del CCHP. El CCHP promueve el uso de la Política de suministros de emergencia a través de mensajes en el punto de venta.

En lugar de utilizar la Política de suministros de emergencia para 5 días, las farmacias también pueden optar por llamar al centro de llamadas del proveedor de PerformRx al 877-234-4269; los representantes están disponibles las 24 horas del día, los 365 días del año. El personal del centro de llamadas tiene la capacidad de anular las recetas en función de la orientación proporcionada por el CCHP.

¿Qué sucede si soy un miembro nuevo del CCHP?

Si es un miembro nuevo del CCHP, puede estar tomando medicamentos que no están en nuestro formulario, o puede estar tomando medicamentos que están en nuestro formulario, pero que tienen límites. Si es posible, debe hablar con su médico para ver si puede cambiar a un medicamento preferido en el formulario del CCHP. Si no puede cambiarse a un medicamento preferido, entonces su médico deberá solicitarle al CCHP una excepción para cubrir un medicamento que ha estado tomando (conocido como continuación del tratamiento). Consulte la sección anterior titulada "¿Qué sucede si el medicamento que necesito no figura en el formulario del CCHP?" para obtener más información.

¿El CCHP cubre medicamentos genéricos y de marca?

El CCHP cubre medicamentos de marca y genéricos, pero cuando hay un medicamento genérico disponible, el CCHP requiere que se use. Todos los medicamentos que están disponibles genéricamente están sujetos a revisión por parte del comité de Farmacia y Terapéutica del CCHP.

Una persona que emite una receta puede solicitar un producto de marca en lugar de un genérico aprobado si determina que existe una necesidad médica documentada del equivalente de marca. Este tipo de solicitud de cobertura se puede realizar a través del proceso de autorización previa del CCHP descrito anteriormente en la sección titulada "¿Qué sucede si el medicamento que necesito no está indicado en el formulario del CCHP?"

¿Hay medicamentos que están excluidos de la cobertura?

El formulario de Medi-Cal del CCHP es muy similar a la Lista de Medicamentos con Contrato de Medi-Cal de California. Los siguientes tipos de medicamentos generalmente no son un beneficio cubierto para los miembros de Medi-Cal (tenga en cuenta que esta lista está sujeta a cambios):

- Medicamentos para la disfunción eréctil o sexual
- Medicamentos utilizados por razones estéticas o crecimiento del cabello
- Medicamentos que se consideran experimentales, o que se usan de manera experimental
- Medicamentos utilizados para tratar la infertilidad
- Medicamentos específicamente enumerados como "no cubiertos" en el formulario
- Medicamentos extranjeros o medicamentos no aprobados por la Administración de Alimentos y Medicamentos de los Estados Unidos (FDA)

Si se modifica la cobertura del CCHP para excluir un medicamento que hemos estado cubriendo y proporcionándole bajo su cobertura actual, continuaremos proporcionándole el medicamento si un médico del plan continúa recetándolo para la misma afección y para un uso aprobado por la Administración de Alimentos y Medicamentos.

Algunos medicamentos están excluidos por el Departamento de Servicios de Atención Médica. Esto significa que estos medicamentos están cubiertos por el programa de

pago por servicio de Medi-Cal para miembros de Medi-Cal, no por el CCHP. Los siguientes tipos de medicamentos están excluidos:

- Medicamentos antipsicóticos
- Medicamentos para el VIH/sida
- Medicamentos exclusivos para el tratamiento de desintoxicación y dependencia del alcohol y heroína
- Medicamentos exclusivos para tratar la hemofilia

¿Puedo ir a cualquier farmacia por mi medicamento?

No, los miembros deben usar una farmacia que esté en la red del CCHP. Para encontrar una farmacia de la red, visite el sitio web del CCHP o llame al plan de salud directamente para que uno de los miembros del personal de servicios para miembros o de farmacia le ayuden a ubicar una farmacia cercana (consulte la sección a continuación titulada "¿Cómo encuentro una farmacia?").

¿Cómo encuentro una farmacia?

Para encontrar una farmacia cercana, visite el sitio web del CCHP en <https://cchealth.org/healthplan/>. Una vez que haya navegado al sitio web del CCHP, siga las instrucciones a continuación:

- (1) Desplácese hacia abajo y haga clic en el botón "Buscar médicos/clínicas/farmacias en mi área" (Search Doctors/Clinics/Pharmacies in My Area)
- (2) Haga clic en el botón rojo "Comenzar aquí" (Begin Your Search Here) (se abrirá una nueva ventana)
- (3) Haga clic en la pestaña "Instalaciones" (Facility) y elija "Farmacia" (Pharmacy) como tipo de instalación
- (4) Elija cómo desea buscar (por código postal, distancia, etc.)
- (5) Haga clic en "Buscar una instalación" (Find a Facility): los resultados aparecerán inmediatamente (como un mapa y una lista)

Asegúrese de mostrar su tarjeta de identificación de miembro del CCHP cuando surta sus recetas en la farmacia.

Nota: algunos medicamentos están sujetos a una distribución limitada por parte de la Administración de Alimentos y Medicamentos de EE. UU. Estos tipos de medicamentos se denominan "medicamentos de especialidad" porque requieren un manejo especial, coordinación de proveedores o instrucciones especiales que es posible que su farmacia local no le proporcione. El CCHP tiene un contrato con Walgreens para proporcionar este tipo de medicamentos. Si tiene preguntas específicas sobre este tipo de medicamentos, comuníquese directamente con la unidad de farmacia del CCHP.

¿Qué medicamentos están cubiertos por el CCHP?

Usted puede obtener los siguientes medicamentos y otros artículos cuando los haya recetado su médico y sean médicamente necesarios:

- Medicamentos recetados que figuran en el formulario del CCHP
- Medicamentos sin receta o medicamentos de venta libre (como jarabes para la tos/resfrío, pastillas para la tos o aspirina) mencionados en el formulario del CCHP
- Suministros para diabéticos del formulario: insulina, jeringas de insulina, tiras reactivas de glucosa, lancetas y dispositivos de punción de lancetas, sistemas de administración de plumas y monitores de glucosa en sangre
- Anticonceptivos aprobados por la FDA que figuran en el formulario del CCHP
- Anticoncepción de emergencia
- Epipens, medidores de flujo máximo y espaciadores

¿Los medicamentos intravenosos (IV) e inyectables están cubiertos por el CCHP?

Sí, el formulario del CCHP enumera ciertos productos inyectables que están cubiertos como un beneficio de farmacia. El CCHP también cubre la mayoría de los demás medicamentos intravenosos a través del beneficio médico. Los medicamentos que generalmente están cubiertos a través del beneficio médico son aquellos que se administran en el consultorio de un médico, clínica u hospital. Las solicitudes de cobertura de un medicamento a través del beneficio médico deben dirigirse al Departamento de Administración de Utilización del CCHP descargando el formulario de referencia médica en <https://cchealth.org/healthplan/providers/> y enviando un fax al (925) 313-6058 para solicitudes de rutina o (925) 313-6458 para solicitudes urgentes.

La cobertura de medicamentos intravenosos e inyectables a través del beneficio de farmacia se detalla a continuación:

- Soluciones intravenosas simples: las soluciones intravenosas simples normalmente se usan para la terapia de hidratación. Se incluyen soluciones comercialmente disponibles (no compuestas) como solución salina normal, dextrosa (hasta 10% en agua) y solución de ringer lactato; las soluciones de cloruro de potasio preparadas comercialmente en tales soluciones también se incluyen en esta definición. Las soluciones intravenosas simples se deben facturar utilizando el número del Código Nacional de Medicamentos (National Drug Code, NDC) del producto.
- Soluciones de nutrición parenteral (TPN o hiperalimentación): restringidas para dispensar dentro de los 10 días posteriores al alta hospitalaria de un hospital de cuidados agudos, cuando se inició la terapia (IV) con el mismo producto antes del alta. Hay un suministro máximo para 10 días por dispensación dentro de este período de 10 días. (Las soluciones de nutrición parenteral son productos nutricionales administrados por vía intravenosa o intraarterial que suelen ser suspensiones o soluciones de aminoácidos o proteínas, dextrosa, lípidos, electrolitos, suplementos vitamínicos y/o minerales y oligoelementos). Los complementos a la nutrición parenteral son otros medicamentos que se mezclan físicamente con una solución de nutrición parenteral en cualquier momento antes de

la administración. Facture estos productos como parte de la facturación de nutrición parenteral. **Nota:** Los productos no compuestos deben facturarse utilizando el número NDC del producto. Las soluciones compuestas deben facturarse como un reclamo compuesto.

- Lípidos intravenosos administrados por separado: restringidos para ser dispensados dentro de los 10 días posteriores al alta hospitalaria de un hospital de cuidados agudos, cuando la terapia (IV) con el mismo producto se haya iniciado antes del alta. Hay un suministro máximo para 10 días por dispensación dentro de este período de 10 días. Las soluciones o suspensiones de lípidos intravenosos que se administran por separado de las soluciones de nutrición parenteral (es decir, no se mezclan físicamente en el recipiente de la solución de nutrición parenteral) deben facturarse utilizando el número NDC del producto.
- Soluciones intravenosas de antibióticos no incluidos en la lista: restringidas para ser dispensadas dentro de los 10 días posteriores al alta hospitalaria de un hospital de cuidados agudos, cuando la terapia IV con el mismo antibiótico se haya iniciado antes del alta. Hay un suministro máximo para 10 días por dispensación dentro del período de 10 días. **Nota:** Los productos no compuestos deben facturarse utilizando el número NDC del producto. Las soluciones compuestas deben facturarse como un reclamo compuesto.
- Soluciones intravenosas de otros medicamentos no indicados en la lista: restringidas para ser dispensadas dentro de los 10 días posteriores al alta hospitalaria de un hospital de cuidados agudos, cuando la terapia IV con el mismo medicamento se haya iniciado antes del alta. Hay un suministro máximo para 10 días por dispensación dentro del período de 10 días. **Nota:** Los productos no compuestos deben facturarse utilizando el número NDC del producto. Las soluciones compuestas deben facturarse como un reclamo compuesto.

¿Cuánto pagaré por mis medicamentos?

Los miembros de Medi-Cal del CCHP **no** tienen que pagar los servicios cubiertos; los medicamentos están disponibles sin copago.

Los miembros comerciales del CCHP (con planes como el plan comercial A, el plan B, IHSS, etc.) pueden tener que pagar pequeños copagos por sus medicamentos.

Consulte los materiales de su plan para determinar si tiene un copago.

¿Los proveedores pueden hacer sugerencias al CCHP para mejorar el formulario?

Por supuesto que sí. El formulario es una herramienta para promover el uso rentable de medicamentos recetados. El CCHP ha hecho todo lo posible para crear un documento que satisfaga todas las necesidades terapéuticas; sin embargo, el arte de la medicina hace que esta sea una tarea formidable. El CCHP agradece la participación de médicos, farmacéuticos y proveedores de servicios médicos auxiliares en este proceso dinámico. Se alienta a los médicos y farmacéuticos a dirigir

cualquier sugerencia o comentario al CCHP por correo electrónico a:
cchp_pharmacy_director@hsd.cccounty.us.

¿Qué puedo hacer si necesito más información?

Para obtener más información sobre sus beneficios de farmacia, revise los documentos de su Evidencia de cobertura o llame al CCHP directamente para hablar sobre ellos. El departamento de servicios para miembros del CCHP y el personal del departamento de farmacia están disponibles para responder preguntas de lunes a viernes de 8 a.m. a 5 p.m., hora del Pacífico, en los números de teléfono que se detallan a continuación:

Departamento de Servicios a Miembros del CCHP: **(877) 661-6230 x2**

Departamento de Farmacia del CCHP: **(877) 661-6230 x3**

Definiciones y abreviaturas:

En este documento, se usan varios términos que el Plan de Salud Contra Costa quiere asegurarse de que usted entienda. A continuación se presentan algunas definiciones y abreviaturas:

“Medicamento de marca” es un medicamento que se comercializa bajo un nombre patentado y protegido por marca registrada. El medicamento de marca aparece en todas las letras en MAYÚSCULAS.

“Coseguro” es un porcentaje del costo de un beneficio de atención médica cubierto que un afiliado paga después de que haya pagado el deducible, si se aplica un deducible al beneficio de atención médica, como el beneficio de medicamentos recetados.

“Copago” es un monto fijo en dólares que un afiliado paga por un beneficio de atención médica cubierto después de que haya pagado el deducible, si se aplica un deducible al beneficio de atención médica, como el beneficio de medicamentos recetados.

“Deducible” es el monto que un afiliado paga por los beneficios de atención médica cubiertos antes de que el plan de salud del afiliado comience a pagar la totalidad o parte del costo del beneficio de atención médica según los términos de la póliza.

“Nivel de medicamento” es un grupo de medicamentos recetados que corresponde a un nivel de costo compartido especificado en la cobertura de medicamentos recetados del plan de salud. El nivel en el que se coloca un medicamento recetado determina la parte del costo del medicamento para el afiliado.

“Afiliado” es una persona inscrita en un plan de salud que tiene derecho a recibir servicios del plan. Todas las referencias a los afiliados en esta plantilla del formulario también incluirán suscriptores como se define en esta sección a continuación.

“Solicitud de excepción” es una solicitud de cobertura de un medicamento recetado. Si un afiliado, su persona designada o el proveedor de atención médica que emite la receta presenta una solicitud de excepción para la cobertura de un medicamento recetado, el plan de salud debe cubrir el medicamento recetado cuando se determina que el medicamento es médicamente necesario para tratar la afección del afiliado.

“Circunstancias exigentes” se producen cuando un afiliado sufre una afección de salud que puede poner en grave peligro la vida, la salud o la capacidad del afiliado de recuperar su función máxima, o cuando un afiliado se somete a un tratamiento actual con un medicamento que no figura en el formulario.

“**Formulario**” es la lista completa de medicamentos preferidos para su uso y elegibles para la cobertura de un producto del plan de salud, e incluye todos los medicamentos cubiertos bajo el beneficio de medicamentos recetados para pacientes ambulatorios del producto del plan de salud. El formulario también se conoce como una lista de medicamentos recetados,

“**Medicamento genérico**” es el mismo medicamento que su equivalente de marca en dosis, seguridad, concentración, cómo se toma, calidad, rendimiento y uso previsto. Un medicamento genérico aparece en *letra minúscula negrita y cursiva*.

“**Medicamento que no figura en el formulario**” es un medicamento recetado que no figura en el formulario del plan de salud.

“**Costo de bolsillo**” son copagos, coseguros y el deducible aplicable, más todos los costos por servicios de atención médica que no están cubiertos por el plan de salud.

“**Proveedor que emite la receta**” es un proveedor de atención médica autorizado para emitir una receta médica para tratar una afección médica de un afiliado al plan de salud.

“**Receta**” es una orden oral, escrita o electrónica de un proveedor que emite recetas para un afiliado específico que contiene el nombre del medicamento recetado, la cantidad del medicamento recetado, la fecha de emisión, el nombre y la información de contacto del proveedor que receta, la firma del proveedor que emite recetas si la receta es por escrito, y si la persona inscrita lo solicita, la afección médica o el propósito para el cual se receta el medicamento.

“**Medicamento recetado**” es un medicamento recetado por el proveedor del afiliado que emite recetas y requiere una receta en virtud de la ley aplicable.

“**Autorización previa**” es un requisito del plan de salud de que el afiliado o el proveedor del afiliado que emite recetas obtenga la autorización del plan de salud para un medicamento recetado antes de que el plan de salud cubra el medicamento. El plan de salud otorgará una autorización previa cuando sea médicamente necesario que el afiliado obtenga el medicamento.

“**Tratamiento escalonado**” es un proceso que especifica la secuencia en la que se recetan diferentes medicamentos recetados para una afección médica determinada y médicamente apropiados para un paciente en particular. El plan de salud puede requerir que el afiliado pruebe uno o más medicamentos para tratar la afección médica del afiliado antes de que el plan de salud cubra un medicamento en particular para la afección de conformidad con una solicitud de tratamiento escalonado. Si el proveedor que emite recetas al afiliado presenta una solicitud de excepción de tratamiento

escalonado, los planes de salud harán excepciones al tratamiento escalonado cuando se cumplan los criterios.

“**Suscriptor**” es la persona responsable del pago de un plan o cuyo empleo u otra circunstancia, excepto la dependencia familiar, es la base para la elegibilidad para la membresía en el plan.

A continuación se explican abreviaturas y términos adicionales utilizados en el documento del formulario del CCHP:

Abreviatura	Término	Qué significa
AL	Límite de edad	Algunos medicamentos solo están cubiertos para ciertas edades.
NF	No figura en el formulario	Estos medicamentos no están cubiertos en la Lista de medicamentos. Si su médico considera que necesita un medicamento que no está cubierto, puede solicitarnos que hagamos una excepción.
PA	Autorización previa	Su médico debe solicitar la aprobación del CCHP antes de que se cubran algunos medicamentos.
QL	Límite de cantidad	Algunos medicamentos solo están cubiertos para ciertas cantidades.
SCO	Exclusión estatal	Estos medicamentos están excluidos por el Departamento de Servicios de Atención Médica. Esto significa que estos medicamentos están cubiertos por el programa de tarifa por servicio de Medi-Cal y deben ser facturados al estado por la farmacia.
ST	Tratamiento escalonado	En algunos casos, primero debe probar ciertos medicamentos antes de que CalViva Health cubra otro medicamento para su afección médica. Por ejemplo, si el Medicamento A y el Medicamento B tratan su afección de salud, es posible que el CCHP no cubra el Medicamento B a menos que pruebe el Medicamento A primero.

El formulario del CCHP utiliza una estructura de 3 niveles; los niveles se explican a continuación:

Abreviatura	Término	Qué significa
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T1	Nivel 1	Los medicamentos de nivel 1 se prefieren en el formulario del CCHP y están disponibles sin restricción o autorización previa.
T2	Nivel 2	Los medicamentos de nivel 2 se prefieren en el formulario del CCHP y están disponibles sin autorización previa, PERO pueden tener ciertas restricciones, como límites de cantidad, tratamiento escalonado, etc. (las restricciones específicas se enumeran en el formulario del CCHP).
T3	Nivel 3	Los medicamentos de nivel 3 no son preferidos. Estos medicamentos requieren autorización previa.

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Informational Section

CURRENT AS OF 3/01/2026

<p>bold italics = Generic drugs UPPERCASE = Brand name drugs</p>	<p>Drug Tier SCO = State Carve Out T1 = Preferred Medication T2 = Preferred Medication with Restriction T3 = Non-Preferred Medication - Prior Authorization is Required</p>	<p>Coverage Requirements and Limits AL = Age Limit PA = Prior Authorization QL = Quantity Limit SCO = State Carve Out ST = Step Therapy</p>
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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antidote Therapeutics		
Acetaminophen Antidote		
<i>Acetylcysteine Inhalation</i>	T1	
Alcohol Deterrents (91:02)		
<i>Acamprosate Calcium</i>	T1	
<i>Disulfiram Oral</i>	T1	
<i>Naltrexone HCl Oral</i>	T1	
VIVITROL (<i>Naltrexone</i>)	T1	
Antidote Therapeutics		
<i>Atropine Sulfate Ophthalmic Solution 1 %</i>	T1	
BAQSIMI ONE PACK (<i>Glucagon</i>)	T1	
BAQSIMI TWO PACK (<i>Glucagon</i>)	T1	
CHEMET (<i>Succimer</i>)	T1	
<i>Deferoxamine Mesylate</i>	T1	PA
<i>Glucagon Emergency Injection Solution Reconstituted</i>	T1	
<i>GNP Naloxone HCl</i>	T1	
<i>Hyoscyamine Sulfate ER Oral Tablet Extended Release 12 Hour</i>	T1	
<i>Hyoscyamine Sulfate Oral</i>	T1	
<i>Hyoscyamine Sulfate Sublingual</i>	T1	
<i>Hyosyne</i>	T1	
<i>Iodine Strong Oral</i>	T1	
KLOXXADO (<i>Naloxone HCl</i>)	T1	QL (4 EA per 180 days)
<i>Magnesium Sulfate Injection Solution 50 %</i>	T1	
<i>Naloxone HCl Injection Solution 0.4 MG/ML, 4 MG/10ML</i>	T1	
<i>Naloxone HCl Injection Solution Cartridge</i>	T1	

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bold italics = Generic drugs UPPERCASE = Brand name drugs	Drug Tier	Coverage Requirements and Limits
	SCO = State Carve Out T1 = Preferred Medication T2 = Preferred Medication with Restriction T3 = Non-Preferred Medication - Prior Authorization is Required	AL = Age Limit PA = Prior Authorization QL = Quantity Limit SCO = State Carve Out ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Naloxone HCl Injection Solution Prefilled Syringe 2 MG/2ML</i>	T1	
<i>Naloxone HCl Nasal</i>	T1	
<i>NULEV (Hyoscyamine Sulfate)</i>	T1	
<i>Oscimin Oral Tablet</i>	T1	
<i>Oscimin Sublingual</i>	T1	
<i>penicillAMINE Oral</i>	T1	PA
<i>Phytonadione Injection Solution 1 MG/0.5ML, 10 MG/ML</i>	T1	
<i>Phytonadione Oral</i>	T1	
<i>REXTOVY (Naloxone HCl)</i>	T1	QL (4 EA per 180 days)
<i>RIVIVE (Naloxone HCl)</i>	T1	QL (4 EA per 180 days)
<i>Vitamin K1 Injection Solution 1 MG/0.5ML, 10 MG/ML</i>	T1	
Antidotes (91:04)		
<i>Atropine Sulfate Injection Solution 8 MG/20ML</i>	T1	
<i>Atropine Sulfate Injection Solution Prefilled Syringe 0.25 MG/5ML, 0.5 MG/5ML, 1 MG/10ML</i>	T1	
<i>Magnesium Sulfate Injection Solution 50 %</i>	T1	
<i>Naloxone HCl Injection Solution 0.4 MG/ML, 4 MG/10ML</i>	T1	
<i>Naloxone HCl Injection Solution Cartridge</i>	T1	
<i>Naloxone HCl Injection Solution Prefilled Syringe 2 MG/2ML</i>	T1	
<i>Naltrexone HCl Oral</i>	T1	
<i>Sevelamer Carbonate Oral Tablet</i>	T1	
<i>Sevelamer HCl</i>	T1	PA
<i>VIVITROL (Naltrexone)</i>	T1	
Chemotherapy Antidotes/Protectants		
<i>LEDERLE LEUCOVORIN (Leucovorin Calcium)</i>	T1	
<i>Leucovorin Calcium Oral Tablet 5 MG</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Cyanide Antidotes		
EXODERM EXTERNAL LOTION (<i>Sod Thiosulfate-Salicylic Acd</i>)	T1	
Antihistamine Drugs		
Antihistamine Drugs		
<i>Promethazine HCl Oral Tablet 25 MG</i>	T1	
Ethanolamine Derivatives		
<i>Carbinoxamine Maleate Oral Solution</i>	T1	
<i>Carbinoxamine Maleate Oral Tablet 4 MG</i>	T1	
<i>Clemastine Fumarate Oral Syrup</i>	T1	
<i>Clemastine Fumarate Oral Tablet 2.68 MG</i>	T1	
<i>CVS Itch Relief External Gel</i>	T1	
<i>diphenhydrAMINE HCl Oral Capsule 25 MG</i>	T1	
<i>diphenhydrAMINE HCl Oral Elixir</i>	T1	
First Gen. Antihist. Derivatives, Misc.		
<i>Cyproheptadine HCl Oral</i>	T1	
First Generation Antihistamines		
<i>Carbinoxamine Maleate Oral Solution</i>	T1	
<i>Carbinoxamine Maleate Oral Tablet 4 MG</i>	T1	
<i>Clemastine Fumarate Oral Syrup</i>	T1	
<i>Clemastine Fumarate Oral Tablet 2.68 MG</i>	T1	
<i>CVS Itch Relief External Gel</i>	T1	
<i>Cyproheptadine HCl Oral</i>	T1	
<i>diphenhydrAMINE HCl Oral Capsule 25 MG</i>	T1	
<i>diphenhydrAMINE HCl Oral Elixir</i>	T1	
<i>Hydrocod Poli-Chlorphe Poli ER</i>	T1	QL (240 ML per 30 days); AL (Min 18 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>hydrOXYzine HCl Oral Syrup</i>	T1	
<i>hydrOXYzine HCl Oral Tablet</i>	T1	
<i>hydrOXYzine Pamoate Oral</i>	T1	
<i>Meclizine HCl Oral Tablet 12.5 MG, 25 MG</i>	T1	
<i>Meclizine HCl Oral Tablet Chewable</i>	T1	
<i>Promethazine HCl Oral Solution 6.25 MG/5ML</i>	T1	
<i>Promethazine HCl Oral Tablet</i>	T1	
<i>Promethazine HCl Rectal Suppository 12.5 MG, 25 MG</i>	T1	
<i>Promethazine-Codeine</i>	T1	QL (240 ML per 30 days); AL (Min 18 Years)
<i>Promethazine-DM Oral Syrup 6.25-15 MG/5ML</i>	T1	
PROMETHEGAN (<i>Promethazine HCl</i>)	T1	
<i>Pseudoeph-Bromphen-DM Oral Syrup 30-2-10 MG/5ML</i>	T1	PA
Other Antihistamines		
<i>Cimetidine Oral</i>	T1	
<i>Famotidine Oral Suspension Reconstituted</i>	T1	
<i>Famotidine Oral Tablet 20 MG, 40 MG</i>	T1	
<i>hydrOXYzine HCl Oral Syrup</i>	T1	
<i>hydrOXYzine HCl Oral Tablet</i>	T1	
<i>hydrOXYzine Pamoate Oral</i>	T1	
<i>Olopatadine HCl Ophthalmic</i>	T1	
Phenothiazine Derivatives		
<i>Promethazine HCl Oral Solution 6.25 MG/5ML</i>	T1	
<i>Promethazine HCl Oral Tablet</i>	T1	
<i>Promethazine HCl Rectal Suppository 12.5 MG, 25 MG</i>	T1	
<i>Promethazine-Codeine</i>	T1	QL (240 ML per 30 days); AL (Min 18 Years)
<i>Promethazine-DM Oral Syrup 6.25-15 MG/5ML</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROMETHEGAN (<i>Promethazine HCl</i>)	T1	
Piperazine Derivatives		
<i>hydrOXYzine HCl Oral Syrup</i>	T1	
<i>hydrOXYzine HCl Oral Tablet</i>	T1	
<i>hydrOXYzine Pamoate Oral</i>	T1	
<i>Meclizine HCl Oral Tablet 12.5 MG, 25 MG</i>	T1	
<i>Meclizine HCl Oral Tablet Chewable</i>	T1	
Propylamine Derivatives		
<i>Hydrocod Poli-Chlorphe Poli ER</i>	T1	QL (240 ML per 30 days); AL (Min 18 Years)
<i>Pseudoeph-Bromphen-DM Oral Syrup 30-2-10 MG/5ML</i>	T1	PA
Second Generation Antihistamines		
<i>All Day Allergy Childrens Oral Solution 5 MG/5ML</i>	T1	
<i>All-Day Allergy Childrens</i>	T1	
<i>Allergy Childrens Oral Solution</i>	T1	
<i>Allergy Childrens Oral Suspension</i>	T1	ST
<i>Allergy Rel Child (Loratadine)</i>	T1	
<i>Allergy Relief Childrens Oral Solution 1 MG/ML</i>	T1	
<i>Allergy Relief Oral Tablet 5 MG</i>	T1	
<i>Cetirizine HCl Allergy Child</i>	T1	
<i>Cetirizine HCl Childrens Alrgy Oral Solution</i>	T1	
<i>Cetirizine HCl Oral Solution 1 MG/ML</i>	T1	
<i>Cetirizine HCl Oral Tablet Chewable</i>	T1	
<i>Childrens 24 Hour Allergy</i>	T1	
<i>Childrens Loratadine Oral Solution</i>	T1	
<i>CVS Allergy Childrens Oral Solution</i>	T1	
<i>CVS Allergy Relief Childrens Oral Solution</i>	T1	
<i>CVS Allergy Relief Childrens Oral Suspension</i>	T1	ST

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CVS Allergy Relief Oral Tablet 5 MG	T1	
CVS Allergy Relief Oral Tablet Dispersible 5 MG	T1	
CVS Allergy Relief(Cetirizine)	T1	
Desloratadine Oral Tablet	T1	PA
Desloratadine Oral Tablet Dispersible 5 MG	T1	PA
Epinastine HCl	T1	PA
EQ Allerg Relief Child (Cetir)	T1	
EQ Allerg Relief Child (Lorat)	T1	
EQ Allergy Childrens Oral Solution	T1	
EQ Allergy Relief (Cetirizine) Oral Solution	T1	
EQ Cetirizine HCl Oral Solution	T1	
EQL All Day Allergy Childrens	T1	
GNP All Day Allergy Childrens Oral Solution	T1	
GNP Allergy Relief 24 HR	T1	
GNP Loratadine Childrens Oral Solution	T1	
GNP Loratadine Oral Solution	T1	
GoodSense All Day Allergy Oral Solution	T1	
KLS ALLER-TEC CHILDRENS ORAL SOLUTION 5 MG/5ML (Cetirizine HCl)	T1	
Levocetirizine Dihydrochloride Oral Tablet	T1	
Loratadine Childrens Oral Solution	T1	
Loratadine Oral Solution	T1	
QC All Day Allergy	T1	
WAL-ITIN CHILDRENS (Loratadine)	T1	
WAL-ITIN ORAL SOLUTION (Loratadine)	T1	
WAL-ZYR ALL DAY ALLERGY CHILD (Cetirizine HCl)	T1	
WAL-ZYR ALLERGY CHILDRENS (Cetirizine HCl)	T1	
WAL-ZYR CHILDRENS ORAL SOLUTION (Cetirizine HCl)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
WAL-ZYR CHILDRENS ORAL TABLET CHEWABLE 10 MG (<i>Cetirizine HCl</i>)	T1	
Anti-Infective Agents		
1St Generation Cephalosporin Antibiotics		
<i>Cefadroxil</i>	T1	
<i>Cephalexin Oral Capsule 250 MG, 500 MG</i>	T1	
<i>Cephalexin Oral Suspension Reconstituted</i>	T1	
<i>Cephalexin Oral Tablet</i>	T1	PA
2Nd Generation Cephalosporin Antibiotics		
<i>Cefaclor ER</i>	T1	PA
<i>Cefaclor Oral Capsule</i>	T1	
<i>Cefaclor Oral Suspension Reconstituted 250 MG/5ML</i>	T1	
<i>Cefprozil</i>	T1	
<i>Cefuroxime Axetil Oral Tablet</i>	T1	
3Rd Generation Cephalosporin Antibiotics		
<i>Cefdinir Oral Capsule</i>	T1	QL (60 EA per 30 days)
<i>Cefdinir Oral Suspension Reconstituted 125 MG/5ML</i>	T1	QL (9000 ML per 30 days)
<i>Cefdinir Oral Suspension Reconstituted 250 MG/5ML</i>	T1	QL (6000 ML per 30 days)
<i>Cefixime Oral Capsule</i>	T1	QL (2 EA per 30 days)
<i>Cefpodoxime Proxetil Oral Suspension Reconstituted</i>	T1	
<i>Cefpodoxime Proxetil Oral Tablet</i>	T1	QL (112 EA per 180 days)
<i>CefTAZidime</i> (Tazicef Intravenous Solution Reconstituted 2 Gm)	T1	
Adamantane Antivirals		
<i>Amantadine HCl Oral Capsule</i>	T1	
<i>Amantadine HCl Oral Solution 50 MG/5ML</i>	T1	
<i>Amantadine HCl Oral Tablet</i>	T1	
<i>riMANTAdine HCl</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Allylamine Antifungals		
<i>Athletes Foot (Terbinafine)</i>	T1	
<i>CVS Athletes Foot External Cream</i>	T1	
<i>CVS Jock Itch</i>	T1	
<i>EQ Athletes Foot (Terbinafine)</i>	T1	
<i>GNP Terbinafine Hydrochloride</i>	T1	
LAMISIL AT ATHLETES FOOT (<i>Terbinafine HCl</i>)	T1	
<i>Terbinafine HCl External</i>	T1	
<i>Terbinafine HCl Oral</i>	T1	
Amebicides		
<i>Chlorhexidine Gluconate Mouth/Throat</i>	T1	
<i>Hydrocortisone-Iodoquinol External Cream 1-1 %</i>	T1	
<i>metroNIDAZOLE External Cream</i>	T1	QL (45 GM per 30 days)
<i>metroNIDAZOLE External Gel 0.75 %</i>	T1	QL (45 GM per 30 days)
<i>metroNIDAZOLE External Gel 1 %</i>	T1	QL (60 GM per 30 days)
<i>metroNIDAZOLE Oral Capsule</i>	T1	
<i>metroNIDAZOLE Oral Tablet 250 MG, 500 MG</i>	T1	
<i>metroNIDAZOLE Vaginal</i>	T1	
NORITATE (<i>MetroNIDAZOLE</i>)	T1	PA
<i>Chlorhexidine Gluconate</i> (Periogard)	T1	
Aminoglycoside Antibiotics		
<i>Gentamicin Sulfate External</i>	T1	
<i>Gentamicin Sulfate Ophthalmic Solution</i>	T1	
<i>Neomycin Sulfate Oral</i>	T1	
<i>Streptomycin Sulfate Intramuscular</i>	T1	QL (1 EA per 30 days)
TOBRADEX OPHTHALMIC OINTMENT (<i>Tobramycin-Dexamethasone</i>)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Tobramycin Inhalation Nebulization Solution 300 MG/5ML</i>	T1	PA
<i>Tobramycin Ophthalmic</i>	T1	
<i>Tobramycin-Dexamethasone</i>	T1	
TOBREX OPHTHALMIC OINTMENT (<i>Tobramycin</i>)	T1	
Aminopenicillin Antibiotics		
<i>Amoxicill-Clarithro-Lansopraz Oral Therapy Pack</i>	T1	PA
<i>Amoxicillin Oral Capsule</i>	T1	
<i>Amoxicillin Oral Suspension Reconstituted</i>	T1	
<i>Amoxicillin Oral Tablet</i>	T1	
<i>Amoxicillin Oral Tablet Chewable 125 MG, 250 MG</i>	T1	
<i>Amoxicillin-Pot Clavulanate ER</i>	T1	
<i>Amoxicillin-Pot Clavulanate Oral Suspension Reconstituted</i>	T1	
<i>Amoxicillin-Pot Clavulanate Oral Tablet</i>	T1	
<i>Ampicillin Oral Capsule 500 MG</i>	T1	
<i>Ampicillin Sodium Injection Solution Reconstituted 1 GM, 2 GM, 500 MG</i>	T1	
<i>Ampicillin-Sulbactam Sodium Injection Solution Reconstituted 1.5 (1-0.5) GM, 3 (2-1) GM</i>	T1	
Anthelmintics		
<i>Albendazole Oral</i>	T1	PA
EMVERM (<i>Mebendazole</i>)	T1	QL (60 EA per 30 days)
<i>Ivermectin Oral Tablet 3 MG</i>	T1	QL (30 EA per 365 days)
<i>Praziquantel Oral</i>	T1	PA
Antifungals, Miscellaneous		
<i>Griseofulvin Microsize Oral</i>	T1	
<i>Griseofulvin Ultramicrosize Oral Tablet 125 MG, 250 MG</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Iodine Strong Oral</i>	T1	
Antileprosy Agents		
<i>Dapsone Oral</i>	T1	
Antimalarials		
<i>Atovaquone-Proguanil HCl Oral Tablet 250-100 MG</i>	T1	QL (180 EA per 365 days)
<i>Atovaquone-Proguanil HCl Oral Tablet 62.5-25 MG</i>	T1	QL (540 EA per 365 days)
<i>Avidoxy</i>	T1	
<i>Chloroquine Phosphate Oral</i>	T1	
<i>Doxycycline Hyclate</i> (Doxy 100)	T1	
<i>Doxycycline Hyclate Oral Capsule</i>	T1	
<i>Doxycycline Hyclate Oral Tablet 100 MG</i>	T1	
<i>Doxycycline Hyclate Oral Tablet 20 MG</i>	T1	PA
<i>Doxycycline Monohydrate Oral Capsule 100 MG, 50 MG</i>	T1	
<i>Doxycycline Monohydrate Oral Suspension Reconstituted</i>	T1	
<i>Doxycycline Monohydrate Oral Tablet 100 MG, 50 MG, 75 MG</i>	T1	
<i>Hydroxychloroquine Sulfate Oral Tablet 200 MG</i>	T1	
<i>Mefloquine HCl</i>	T1	
<i>Minocycline HCl Oral Capsule 100 MG</i>	T1	QL (60 EA per 30 days)
<i>Minocycline HCl Oral Capsule 50 MG</i>	T1	
<i>Doxycycline Monohydrate</i> (Mondoxyne NI Oral Capsule 100 Mg)	T1	
<i>Primaquine Phosphate Oral Tablet 26.3 (15 Base) MG</i>	T1	
<i>Pyrimethamine Oral</i>	T1	
<i>quiNIDine Gluconate ER</i>	T1	
<i>quiNIDine Sulfate Oral</i>	T1	
<i>QuiNINE Sulfate Oral</i>	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Tetracycline HCl Oral Capsule</i>	T1	
Antimycobacterials, Miscellaneous		
<i>Dapsone Oral</i>	T1	
Antiprotozoals, Cryptosporidiosis		
<i>Nitazoxanide Oral</i>	T1	
Antiprotozoals, Miscellaneous		
<i>Atovaquone Oral</i>	T1	PA
<i>Dapsone Oral</i>	T1	
<i>metroNIDAZOLE Oral Capsule</i>	T1	
<i>metroNIDAZOLE Oral Tablet 250 MG, 500 MG</i>	T1	
<i>Nitazoxanide Oral</i>	T1	
<i>Sulfamethoxazole-Trimethoprim Oral Suspension 200-40 MG/5ML</i>	T1	
<i>Sulfamethoxazole-Trimethoprim Oral Tablet</i>	T1	
<i>Tinidazole Oral</i>	T1	
Antiprotozoals, Nitroimidazole-Derivative		
<i>Tinidazole Oral</i>	T1	
Antituberculosis Agents		
<i>Ciprofloxacin HCl Oral Tablet 250 MG, 500 MG, 750 MG</i>	T1	
<i>Clarithromycin ER</i>	T1	PA
<i>Clarithromycin Oral Suspension Reconstituted</i>	T1	PA
<i>Clarithromycin Oral Tablet</i>	T1	
<i>cycloSERINE Oral</i>	T1	
<i>Ethambutol HCl Oral</i>	T1	
<i>Isoniazid Oral</i>	T1	
<i>levoFLOXacin Oral Solution</i>	T1	
<i>levoFLOXacin Oral Tablet</i>	T1	QL (30 EA per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Moxifloxacin HCl Oral</i>	T1	QL (21 EA per 21 days)
PRIFTIN (<i>Rifapentine</i>)	T1	
<i>Pyrazinamide Oral</i>	T1	
<i>Rifabutin</i>	T1	
<i>rifAMPin Oral</i>	T1	
<i>Streptomycin Sulfate Intramuscular</i>	T1	QL (1 EA per 30 days)
Antivirals, Miscellaneous		
PAXLOVID (150/100) (<i>Nirmatrelvir-Ritonavir</i>)	T1	QL (20 EA per 180 days); AL (Min 12 Years)
PAXLOVID (300/100 & 150/100) (<i>Nirmatrelvir-Ritonavir</i>)	T1	QL (11 EA per 180 days); AL (Min 12 Years)
PAXLOVID (300/100) (<i>Nirmatrelvir-Ritonavir</i>)	T1	QL (30 EA per 180 days); AL (Min 12 Years)
Azole Antifungals		
<i>Fluconazole Oral</i>	T1	
<i>Itraconazole Oral</i>	T1	PA
<i>Ketoconazole External Cream</i>	T1	
<i>Ketoconazole External Shampoo 2 %</i>	T1	
<i>Posaconazole Oral Tablet Delayed Release</i>	T1	PA
<i>Voriconazole Intravenous</i>	T1	PA
<i>Voriconazole Oral</i>	T1	PA
Bacitracin Antibiotics		
<i>Bacitracin Ophthalmic</i>	T1	
<i>Bacitracin-Polymyxin B Ophthalmic Ointment 500-10000 UNIT/GM</i>	T1	
<i>Bacitra-Neomycin-Polymyxin-HC</i>	T1	
<i>EQL Bacitracin Zinc</i>	T1	
Coronavirus (Covid-19)		

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bold italics = Generic drugs UPPERCASE = Brand name drugs	Drug Tier	Coverage Requirements and Limits
	SCO = State Carve Out T1 = Preferred Medication T2 = Preferred Medication with Restriction T3 = Non-Preferred Medication - Prior Authorization is Required	AL = Age Limit PA = Prior Authorization QL = Quantity Limit SCO = State Carve Out ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PAXLOVID (150/100) (<i>Nirmatrelvir-Ritonavir</i>)	T1	QL (20 EA per 180 days); AL (Min 12 Years)
PAXLOVID (300/100 & 150/100) (<i>Nirmatrelvir-Ritonavir</i>)	T1	QL (11 EA per 180 days); AL (Min 12 Years)
PAXLOVID (300/100) (<i>Nirmatrelvir-Ritonavir</i>)	T1	QL (30 EA per 180 days); AL (Min 12 Years)
Erythromycin Antibiotics		
<i>Ery</i>	T1	
<i>Erythromycin Base Oral</i>	T1	
<i>Erythromycin Ethylsuccinate Oral</i>	T1	
<i>Erythromycin External Gel</i>	T1	
<i>Erythromycin External Solution</i>	T1	
<i>Erythromycin Oral</i>	T1	
Glycopeptide Antibiotics		
<i>Vancomycin HCl Oral</i>	T1	
Hcv Polymerase Inhibitor Antivirals		
<i>Sofosbuvir-Velpatasvir</i>	T1	PA
Hcv Protease Inhibitor Antivirals		
MAVYRET (<i>Glecaprevir-Pibrentasvir</i>)	T1	PA
ZEPATIER (<i>Elbasvir-Grazoprevir</i>)	T1	PA
Hcv Replication Complex Inhibitors		
MAVYRET (<i>Glecaprevir-Pibrentasvir</i>)	T1	PA
<i>Sofosbuvir-Velpatasvir</i>	T1	PA
ZEPATIER (<i>Elbasvir-Grazoprevir</i>)	T1	PA
Hiv Nonnucleoside Rev. Transcrip. Inhib.		
<i>Methocarbamol Oral Tablet 500 MG</i>	T1	
Hiv Nucleoside, Nucleotide Rt Inhibitors		

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>lamiVUDine Oral Tablet 100 MG</i>	T1	PA
<i>Tenofovir Disoproxil Fumarate</i>	T1	
VIREAD ORAL POWDER (<i>Tenofovir Disoproxil Fumarate</i>)	T1	
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG (<i>Tenofovir Disoproxil Fumarate</i>)	T1	
Interferon Antivirals		
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>Peginterferon alfa-2a</i>)	T1	PA
Lincomycin Antibiotics		
CLEOCIN VAGINAL SUPPOSITORY (<i>Clindamycin Phosphate</i>)	T1	ST
<i>Clindamycin Phosphate</i> (Clindacin Etz External Swab)	T1	
<i>Clindamycin Phosphate</i> (Clindacin-P)	T1	
<i>Clindamycin HCl Oral</i>	T1	
<i>Clindamycin Phos (Once-Daily)</i>	T1	
<i>Clindamycin Phos (Twice-Daily)</i>	T1	
<i>Clindamycin Phos-Benzoyl Perox External Gel 1-5 %</i>	T1	PA
<i>Clindamycin Phosphate External Lotion</i>	T1	
<i>Clindamycin Phosphate External Solution</i>	T1	
<i>Clindamycin Phosphate External Swab</i>	T1	
<i>Clindamycin Phosphate Vaginal</i>	T1	
Macrolide Antibiotics		
<i>Erythromycin Base Oral</i>	T1	
<i>Erythromycin Ethylsuccinate Oral</i>	T1	
<i>Erythromycin Oral</i>	T1	
Natural Penicillin Antibiotics		
BICILLIN C-R (<i>Penicillin G Benzathine & Proc</i>)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BICILLIN C-R 900/300 (<i>Penicillin G Benzathine & Proc</i>)	T1	
BICILLIN L-A INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>Penicillin G Benzathine</i>)	T1	
<i>Penicillin G Potassium</i>	T1	
<i>Penicillin G Sodium</i>	T1	
<i>Penicillin V Potassium</i>	T1	
<i>Penicillin G Potassium</i> (Pfizerpen)	T1	
Neuraminidase Inhibitor Antivirals		
<i>Oseltamivir Phosphate Oral Capsule</i>	T1	QL (10 EA per 180 days)
<i>Oseltamivir Phosphate Oral Suspension Reconstituted</i>	T1	QL (120 ML per 180 days)
RELENZA DISKHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 5 MG/ACT (<i>Zanamivir</i>)	T1	QL (20 EA per 180 days)
Nitroimidazole Derivatives, Misc		
<i>metroNIDAZOLE External Cream</i>	T1	QL (45 GM per 30 days)
<i>metroNIDAZOLE External Gel 0.75 %</i>	T1	QL (45 GM per 30 days)
<i>metroNIDAZOLE External Gel 1 %</i>	T1	QL (60 GM per 30 days)
<i>metroNIDAZOLE Oral Capsule</i>	T1	
<i>metroNIDAZOLE Oral Tablet 250 MG, 500 MG</i>	T1	
<i>metroNIDAZOLE Vaginal</i>	T1	
NORITATE (<i>MetroNIDAZOLE</i>)	T1	PA
Nucleoside And Nucleotide Antivirals		
<i>Acyclovir External</i>	T1	PA
<i>Acyclovir Oral Capsule</i>	T1	
<i>Acyclovir Oral Suspension 200 MG/5ML</i>	T1	
<i>Acyclovir Oral Tablet</i>	T1	
<i>Adefovir Dipivoxil</i>	T1	PA
<i>Entecavir</i>	T1	
<i>Famciclovir Oral</i>	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LAGEVRIO (<i>Molnupiravir</i>)	T1	QL (40 EA per 180 days); AL (Min 18 Years)
<i>Ribavirin Inhalation</i>	T1	PA
<i>valACYclovir HCl Oral</i>	T1	
<i>valGANciclovir HCl Oral Tablet</i>	T1	PA
VEMLIDY (<i>Tenofovir Alafenamide Fumarate</i>)	T1	PA
Other Macrolide Antibiotics		
<i>Amoxicill-Clarithro-Lansopraz Oral Therapy Pack</i>	T1	PA
<i>Azithromycin Oral Suspension Reconstituted</i>	T1	
<i>Azithromycin Oral Tablet 250 MG, 500 MG, 600 MG</i>	T1	
<i>Clarithromycin ER</i>	T1	PA
<i>Clarithromycin Oral Suspension Reconstituted</i>	T1	PA
<i>Clarithromycin Oral Tablet</i>	T1	
Other Macrolides (8:12.12.92)		
<i>Amoxicill-Clarithro-Lansopraz Oral Therapy Pack</i>	T1	PA
<i>Azithromycin Oral Suspension Reconstituted</i>	T1	
<i>Azithromycin Oral Tablet 250 MG, 500 MG, 600 MG</i>	T1	
<i>Clarithromycin ER</i>	T1	PA
<i>Clarithromycin Oral Suspension Reconstituted</i>	T1	PA
<i>Clarithromycin Oral Tablet</i>	T1	
Oxazolidinone Antibiotics		
<i>Linezolid Oral</i>	T1	PA
Penicillinase-Resistant Penicillins		
<i>Dicloxacillin Sodium</i>	T1	
<i>Nafcillin Sodium Injection Solution Reconstituted 1 GM</i>	T1	
<i>Oxacillin Sodium Injection Solution Reconstituted 2 GM</i>	T1	
Polyene Antifungals		

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Nystatin</i> (Nyamyc)	T1	
<i>Nystatin External</i>	T1	
<i>Nystatin Mouth/Throat</i>	T1	
<i>Nystatin Oral Tablet</i>	T1	
<i>Nystatin-Triamcinolone</i>	T1	
<i>Nystatin</i> (Nystop)	T1	
Polymyxin Antibiotics		
<i>Polymyxin B-Trimethoprim</i>	T1	
Quinolone Antibiotics		
<i>Ciprofloxacin HCl Oral Tablet 250 MG, 500 MG, 750 MG</i>	T1	
<i>levoFLOXacin Oral Solution</i>	T1	
<i>levoFLOXacin Oral Tablet</i>	T1	QL (30 EA per 30 days)
<i>Moxifloxacin HCl (2X Day)</i>	T1	PA
<i>Moxifloxacin HCl Ophthalmic Solution</i>	T1	
<i>Moxifloxacin HCl Oral</i>	T1	QL (21 EA per 21 days)
<i>Ofloxacin Ophthalmic</i>	T1	
<i>Ofloxacin Oral Tablet 300 MG, 400 MG</i>	T1	PA
<i>Ofloxacin Otic</i>	T1	
Rifamycin Antibiotics		
PRIFTIN (<i>Rifapentine</i>)	T1	
<i>Rifabutin</i>	T1	
<i>rifAMPin Oral</i>	T1	
XIFAXAN ORAL TABLET 200 MG (<i>Rifaximin</i>)	T1	PA
Sulfonamide Antibiotics (Systemic)		
<i>sulfADIAZINE Oral</i>	T1	
<i>Sulfamethoxazole-Trimethoprim Oral Suspension 200-40 MG/5ML</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Sulfamethoxazole-Trimethoprim Oral Tablet</i>	T1	
<i>sulfaSALazine Oral</i>	T1	
Tetracycline Antibiotics		
<i>Avidoxy</i>	T1	
<i>Demeclocycline HCl Oral</i>	T1	PA
<i>Doxycycline Hyclate</i> (Doxy 100)	T1	
<i>Doxycycline Hyclate Oral Capsule</i>	T1	
<i>Doxycycline Hyclate Oral Tablet 100 MG</i>	T1	
<i>Doxycycline Hyclate Oral Tablet 20 MG</i>	T1	PA
<i>Doxycycline Monohydrate Oral Capsule 100 MG, 50 MG</i>	T1	
<i>Doxycycline Monohydrate Oral Suspension Reconstituted</i>	T1	
<i>Doxycycline Monohydrate Oral Tablet 100 MG, 50 MG, 75 MG</i>	T1	
<i>Minocycline HCl Oral Capsule 100 MG</i>	T1	QL (60 EA per 30 days)
<i>Minocycline HCl Oral Capsule 50 MG</i>	T1	
<i>Doxycycline Monohydrate</i> (Mondoxyne NI Oral Capsule 100 Mg)	T1	
<i>Tetracycline HCl Oral Capsule</i>	T1	
Urinary Anti-Infectives		
<i>Fosfomycin Tromethamine</i>	T1	
<i>Methenamine Hippurate</i>	T1	
<i>Methenamine Mandelate Oral</i>	T1	
<i>Nitrofurantoin Macrocrystal Oral</i>	T1	
<i>Nitrofurantoin Monohyd Macro</i>	T1	
<i>Nitrofurantoin Oral Suspension 25 MG/5ML</i>	T1	
<i>Sulfamethoxazole-Trimethoprim Oral Suspension 200-40 MG/5ML</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Sulfamethoxazole-Trimethoprim Oral Tablet</i>	T1	
<i>Trimethoprim Oral</i>	T1	
Antineoplastic Agents		
Antineoplastic Agents		
ALECENSA (<i>Alectinib HCl</i>)	T1	PA
<i>Anastrozole Oral</i>	T1	QL (30 EA per 30 days)
<i>Bexarotene Oral</i>	T1	PA
<i>Bicalutamide</i>	T1	
CABOMETYX (<i>Cabozantinib S-Malate</i>)	T1	PA
<i>Capecitabine</i>	T1	PA
COTELLIC (<i>Cobimetinib Fumarate</i>)	T1	PA
<i>Cyclophosphamide Oral Tablet 50 MG</i>	T1	
<i>Dasatinib Oral Tablet 100 MG, 20 MG, 50 MG, 70 MG</i>	T1	PA
DROXIA (<i>Hydroxyurea</i>)	T1	
ELIGARD (<i>Leuprolide Acetate (3 Month)</i>)	T1	
<i>Erlotinib HCl</i>	T1	PA
<i>Etoposide Oral</i>	T1	
<i>Exemestane</i>	T1	
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG (<i>Degarelix Acetate</i>)	T1	QL (1 EA per 30 days)
<i>Fluorouracil External Cream 5 %</i>	T1	
<i>Fluorouracil External Solution</i>	T1	
<i>Gefitinib</i>	T1	PA
GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG (<i>Lomustine</i>)	T1	
<i>Hydroxyurea Oral</i>	T1	
IBRANCE (<i>Palbociclib</i>)	T1	PA
ICLUSIG (<i>PONATinib HCl</i>)	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Imatinib Mesylate Oral</i>	T1	PA
JAKAFI (<i>Ruxolitinib Phosphate</i>)	T1	PA
<i>Lapatinib Ditosylate</i>	T1	PA
<i>Lenalidomide</i>	T1	PA
<i>Letrozole Oral</i>	T1	QL (30 EA per 30 days)
LEUKERAN (<i>Chlorambucil</i>)	T1	
LUPRON DEPOT (1-MONTH) (<i>Leuprolide Acetate</i>)	T1	PA
LUPRON DEPOT (3-MONTH) (<i>Leuprolide Acetate (3 Month)</i>)	T1	PA
LUPRON DEPOT (4-MONTH) (<i>Leuprolide Acetate (4 Month)</i>)	T1	PA
LUPRON DEPOT-PED (1-MONTH) (<i>Leuprolide Acetate</i>)	T1	PA
LUPRON DEPOT-PED (3-MONTH) INTRAMUSCULAR KIT 11.25 MG (<i>Leuprolide Acetate (3 Month)</i>)	T1	PA
LYSODREN (<i>Mitotane</i>)	T1	
MATULANE (<i>Procarbazine HCl</i>)	T1	
<i>Megestrol Acetate Oral Suspension 40 MG/ML</i>	T1	
<i>Megestrol Acetate Oral Tablet</i>	T1	
<i>Mercaptopurine Oral Tablet</i>	T1	
<i>Methotrexate Sodium (PF) Injection Solution 1 GM/40ML, 1000 MG/40ML, 250 MG/10ML, 50 MG/2ML</i>	T1	
<i>Methotrexate Sodium Injection Solution 250 MG/10ML, 50 MG/2ML</i>	T1	
<i>Methotrexate Sodium Oral</i>	T1	
MYLERAN (<i>Busulfan</i>)	T1	
<i>Nilutamide</i>	T1	
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>Peginterferon alfa-2a</i>)	T1	PA
POMALYST (<i>Pomalidomide</i>)	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
REVLIMID ORAL CAPSULE 10 MG, 15 MG, 25 MG, 5 MG (<i>Lenalidomide</i>)	T1	PA
SIKLOS (<i>Hydroxyurea</i>)	T1	PA
<i>SORafenib Tosylate</i>	T1	PA
<i>SUNItinib Malate Oral Capsule 12.5 MG, 25 MG, 50 MG</i>	T1	PA
TABLOID (<i>Thioguanine</i>)	T1	
TALZENNA (<i>Talazoparib Tosylate</i>)	T1	PA
<i>Tamoxifen Citrate Oral</i>	T1	
TASIGNA ORAL CAPSULE 200 MG (<i>Nilotinib HCl</i>)	T1	PA
<i>Temozolomide</i>	T1	PA
THALOMID ORAL CAPSULE 100 MG, 50 MG (<i>Thalidomide</i>)	T1	PA
TICE BCG (<i>BCG Live</i>)	T1	
<i>Toremifene Citrate</i>	T1	
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 11.25 MG (<i>Triptorelin Pamoate</i>)	T1	QL (1 EA per 30 days)
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 3.75 MG (<i>Triptorelin Pamoate</i>)	T1	
<i>Tretinoin External Cream</i>	T1	QL (50 GM per 30 days); AL (Max 29 Years)
<i>Tretinoin External Gel 0.01 %, 0.025 %</i>	T1	QL (50 GM per 30 days); AL (Max 29 Years)
<i>Tretinoin Microsphere External Gel 0.04 %, 0.1 %</i>	T1	QL (50 GM per 30 days); AL (Max 29 Years)
<i>Tretinoin Microsphere Pump External Gel 0.04 %, 0.1 %</i>	T1	QL (50 GM per 30 days); AL (Max 29 Years)
<i>Tretinoin Oral</i>	T1	PA
VERZENIO (<i>Abemaciclib</i>)	T1	PA
XALKORI ORAL CAPSULE (<i>Crizotinib</i>)	T1	PA
XTANDI (<i>Enzalutamide</i>)	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZELBORAF (<i>Vemurafenib</i>)	T1	PA
ZOLADEX (<i>Goserelin Acetate</i>)	T1	
ZOLINZA (<i>Vorinostat</i>)	T1	PA
Antitoxins, Immune Glob, Toxoids, Vaccines		
Antitoxins And Immune Globulins		
HYPERRHO (<i>Rho D Immune Globulin</i>)	T1	
RHOGAM ULTRA-FILTERED PLUS INTRAMUSCULAR SOLUTION PREFILLED SYRINGE (<i>Rho D Immune Globulin</i>)	T1	
Toxoids		
ADACEL INTRAMUSCULAR SUSPENSION 5-2-15.5 LF-MCG/0.5 (<i>Tetanus-Diphth-Acell Pertussis</i>)	T1	QL (0.5 ML per 1 FILL)
ADACEL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>Tetanus-Diphth-Acell Pertussis</i>)	T1	QL (0.5 ML per 1 FILL)
BOOSTRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>Tetanus-Diphth-Acell Pertussis</i>)	T1	QL (0.5 ML per 1 FILL)
TENIVAC INTRAMUSCULAR SUSPENSION (<i>Tetanus-Diphtheria Toxoids Td</i>)	T1	QL (0.5 ML per 1 FILL)
VAXELIS INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>DTaP-IPV-Hib-Hepatitis B Recmb</i>)	T1	QL (0.5 ML per 1 Fill)
Vaccines		
ABRYSVO (<i>RSV Pre-Fusion F A&B Vac Rcmb</i>)	T1	QL (1 Vial per 1 Dose)
ACTHIB (<i>Haemophilus B Polysac Conj Vac</i>)	T1	QL (1 ML per 1 Fill)
ADACEL INTRAMUSCULAR SUSPENSION 5-2-15.5 LF-MCG/0.5 (<i>Tetanus-Diphth-Acell Pertussis</i>)	T1	QL (0.5 ML per 1 FILL)
ADACEL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>Tetanus-Diphth-Acell Pertussis</i>)	T1	QL (0.5 ML per 1 FILL)
AFLURIA (<i>Influenza Virus Vaccine Split</i>)	T1	QL (1 ML per 270 days); AL (Min 3 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AFLURIA PRESERVATIVE FREE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>Influenza Virus Vacc Split PF</i>)	T1	QL (1 ML per 270 days); AL (Min 3 Years)
AREXVY (<i>RSVPreF3 Vac Recomb Adjuvanted</i>)	T1	QL (1 Vial per 1 Dose); AL (Min 50 Years)
<i>BCG Vaccine Injection Solution Reconstituted</i>	T1	PA
BEXSERO (<i>Meningococcal B Recomb OMV Adj</i>)	T1	QL (0.5 ML per 1 Fill); AL (Max 25 Years)
BOOSTRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>Tetanus-Diphth-Acell Pertussis</i>)	T1	QL (0.5 ML per 1 FILL)
CAPVAXIVE (<i>Pneumococcal 21-Valent Conjugata</i>)	T1	QL (0.5 lifetime per 1 day); AL (Min 18 Years)
COMIRNATY 5-11 YEARS (<i>COVID-19 mRNA Virus Vaccine</i>)	T1	
COMIRNATY INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>COVID-19 mRNA Virus Vaccine</i>)	T1	
ENGERIX-B INJECTION SUSPENSION 20 MCG/ML (<i>Hepatitis B Vac Recombinant</i>)	T1	QL (2 ML per 1 Fill)
ENGERIX-B INJECTION SUSPENSION PREFILLED SYRINGE (<i>Hepatitis B Vac Recombinant</i>)	T1	QL (2 ML per 1 Fill)
FLUAD (<i>Influenza Vac A&B Surf Ant Adj</i>)	T1	QL (1 ML per 270 days); AL (Min 65 Years)
FLUARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>Influenza Virus Vacc Split PF</i>)	T1	QL (1 ML per 270 days); AL (Min 3 Years)
FLUBLOK INTRAMUSCULAR SOLUTION PREFILLED SYRINGE (<i>Influenza Vac Recombinant HA</i>)	T1	QL (1 ML per 270 days); AL (Min 9 Years)
FLUCELVAX INTRAMUSCULAR SUSPENSION (<i>Influenza Vac Tiss-Cult Subunt</i>)	T1	QL (1 ML per 270 days); AL (Min 3 Years)
FLUCELVAX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>Influenza Vac Tiss-Cult Subunt</i>)	T1	QL (1 ML per 270 days); AL (Min 3 Years)
FLULAVAL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>Influenza Virus Vacc Split PF</i>)	T1	QL (1 ML per 270 days); AL (Min 3 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FLUMIST (<i>Influenza Virus Vaccine Live</i>)	T1	QL (1 EA per 270 days); AL (Min 3 Years and Max 49 Years)
FLUZONE HIGH-DOSE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>Influenza Vac Split High-Dose</i>)	T1	QL (1 ML per 270 days); AL (Min 65 Years)
FLUZONE INTRAMUSCULAR SUSPENSION (<i>Influenza Virus Vaccine Split</i>)	T1	QL (1 ML per 270 days); AL (Min 3 Years)
FLUZONE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>Influenza Virus Vacc Split PF</i>)	T1	QL (1 ML per 270 days); AL (Min 3 Years)
GARDASIL 9 (<i>HPV 9-Valent Recomb Vaccine</i>)	T1	QL (0.5 ML per 1 Fill); AL (Max 45 Years)
HAVRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>Hepatitis A Vaccine</i>)	T1	QL (1 ML per 1 Fill)
HEPLISAV-B INTRAMUSCULAR SOLUTION PREFILLED SYRINGE (<i>Hepatitis B Vac Recomb Adj</i>)	T1	QL (0.5 ML per 1 Fill); AL (Min 18 Years)
HIBERIX INJECTION (<i>Haemophilus B Polysac Conj Vac</i>)	T1	QL (1 ML per 1 Fill)
IMOVAX RABIES INTRAMUSCULAR SUSPENSION RECONSTITUTED (<i>Rabies Virus Vaccine, HDC</i>)	T1	QL (1 ML per 1 Fill)
IPOL INJECTION SUSPENSION (<i>Poliovirus Vaccine Inactivated</i>)	T1	QL (0.5 ML per 1 Fill)
MENQUADFI INTRAMUSCULAR SOLUTION (<i>Mening ACY&W-135 Tetanus Conj</i>)	T1	QL (0.5 ML per 1 Fill)
MENVEO INTRAMUSCULAR SOLUTION (<i>Meningococcal A C Y&W-135 Olig</i>)	T1	QL (0.5 ML per 1 Fill); AL (Max 55 Years)
MENVEO INTRAMUSCULAR SOLUTION RECONSTITUTED (<i>Meningococcal A C Y&W-135 Olig</i>)	T1	QL (1 ml per 1 Fill); AL (Max 55 Years)
M-M-R II INJECTION (<i>Measles, Mumps & Rubella Vac</i>)	T1	QL (1 EA per 1 Fill)
MNEXSPIKE (<i>COVID-19 mRNA Virus Vaccine</i>)	T1	
MRESVIA (<i>RSV mRNA Pre-F Virus Vaccine</i>)	T1	QL (0.5 ML per 1 lifetime); AL (Min 18 Years)
Nuvaxovid COVID-19 Vaccine	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PEDVAX HIB INTRAMUSCULAR SUSPENSION (<i>Haemophilus B Polysac Conj Vac</i>)	T1	QL (0.5 ML per 1 Fill)
PENBRAYA (<i>Mening ACYW(Tet Conj)-B(Rcmb)</i>)	T1	QL (1 vial per 1 Fill); AL (Max 25 Years)
<i>Penmenvy</i>	T1	QL (1 vial per 1 Fill); AL (Min 10 Years and Max 25 Years)
PNEUMOVAX 23 INJECTION SOLUTION PREFILLED SYRINGE (<i>Pneumococcal Vac Polyvalent</i>)	T1	QL (0.5 ML per 1 Dose)
PREVNAR 20 (<i>Pneumococcal 20-Val Conj Vacc</i>)	T1	QL (0.5 ML per 1 Fill)
PRIORIX (<i>Measles, Mumps & Rubella Vac</i>)	T1	QL (1 EA per 1 Fill)
PROQUAD SUBCUTANEOUS SUSPENSION RECONSTITUTED (<i>Measles-Mumps-Rubella-Varicell</i>)	T1	QL (1 EA per 1 Fill)
RABAVERT (<i>Rabies Vaccine, PCEC</i>)	T1	
RECOMBIVAX HB INJECTION SUSPENSION 10 MCG/ML, 40 MCG/ML, 5 MCG/0.5ML (<i>Hepatitis B Vac Recombinant</i>)	T1	QL (1 ML per 1 Fill)
RECOMBIVAX HB INJECTION SUSPENSION PREFILLED SYRINGE (<i>Hepatitis B Vac Recombinant</i>)	T1	QL (1 ML per 1 Fill)
SHINGRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>Zoster Vac Recomb Adjuvanted</i>)	T1	QL (1 syringe per 1 Fill); AL (Min 18 Years)
SHINGRIX INTRAMUSCULAR SUSPENSION RECONSTITUTED 50 MCG/0.5ML (<i>Zoster Vac Recomb Adjuvanted</i>)	T1	QL (1 ML per 1 Fill); AL (Min 18 Years)
SPIKEVAX 6M-11Y (<i>COVID-19 mRNA Virus Vaccine</i>)	T1	
SPIKEVAX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>COVID-19 mRNA Virus Vaccine</i>)	T1	
TICE BCG (<i>BCG Live</i>)	T1	
TRUMENBA (<i>Meningococcal B Vac (Recomb)</i>)	T1	QL (0.5 ML per 1 Fill); AL (Max 25 Years)
TWINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>Hepatitis A-Hep B Recomb Vac</i>)	T1	QL (1 ML per 1 Fill); AL (Min 18 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TYPHIM VI INTRAMUSCULAR SOLUTION PREFILLED SYRINGE (<i>Typhoid VI Polysaccharide Vacc</i>)	T1	QL (0.5 ML per 270 days)
VAQTA INTRAMUSCULAR SUSPENSION 25 UNIT/0.5ML (<i>Hepatitis A Vaccine</i>)	T1	QL (0.5 ML per 1 Fill)
VAQTA INTRAMUSCULAR SUSPENSION 50 UNIT/ML (<i>Hepatitis A Vaccine</i>)	T1	QL (1 ML per 1 Fill)
VAQTA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 25 UNIT/0.5ML (<i>Hepatitis A Vaccine</i>)	T1	QL (0.5 ML per 1 Fill)
VAQTA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 50 UNIT/ML (<i>Hepatitis A Vaccine</i>)	T1	QL (1 ML per 1 Fill)
VARIVAX INJECTION (<i>Varicella Virus Vaccine Live</i>)	T1	QL (1 EA per 1 Dose)
VAXELIS INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>DTaP-IPV-Hib-Hepatitis B Recmb</i>)	T1	QL (0.5 ML per 1 Fill)
VAXNEUVANCE (<i>Pneumococcal 15-Val Conj Vacc</i>)	T1	QL (0.5 ML per 1 Fill)
VIVOTIF (<i>Typhoid Vaccine</i>)	T1	QL (4 EA per 5 years)
Autonomic Drugs		
Alpha- And Beta-Adrenergic Agonists		
<i>Bupivacaine-Epinephrine (PF) Injection Solution 0.25% - 1:200000, 0.5% -1:200000</i>	T1	
<i>BUPIvacaine-EPINEPHrine Injection Solution 0.25% - 1:200000, 0.5% -1:200000</i>	T1	
<i>EPINEPHrine (Anaphylaxis)</i>	T1	
<i>EPINEPHrine Injection Solution 1 MG/ML</i>	T1	
<i>EPINEPHrine Injection Solution Auto-Injector 0.15 MG/0.3ML, 0.3 MG/0.3ML</i>	T1	QL (4 EA per 180 days)
<i>EPINEPHrine PF Injection Solution</i>	T1	
<i>Lidocaine-EPINEPHrine Injection Solution 0.5 %- 1:200000, 1 %-1:100000, 2 %-1:100000</i>	T1	
<i>Pseudoeph-Bromphen-DM Oral Syrup 30-2-10 MG/5ML</i>	T1	PA
<i>Bupivacaine-Epinephrine (Sensorcaine/Epinephrine)</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Bupivacaine-Epinephrine</i> (Sensorcaine-Mpf/Epinephrine Injection Solution 0.25% -1:200000)	T1	
SENSORCAINE-MPF/EPINEPHRINE INJECTION SOLUTION 0.75-1:200000 % (<i>Bupivacaine-Epinephrine</i>)	T1	
XYLOCAINE-MPF/EPINEPHRINE INJECTION SOLUTION 1 %-1:200000 (<i>Lidocaine-Epinephrine</i>)	T1	
Alpha-Adrenergic Agonists (12:12)		
<i>cloNIDine</i>	T1	
<i>cloNIDine HCl Oral</i>	T1	
<i>Methyldopa Oral</i>	T1	
<i>Midodrine HCl</i>	T1	
Antimuscarinics/Antispasmodics		
<i>Atropine Sulfate Injection Solution 8 MG/20ML</i>	T1	
<i>Atropine Sulfate Injection Solution Prefilled Syringe 0.25 MG/5ML, 0.5 MG/5ML, 1 MG/10ML</i>	T1	
<i>Atropine Sulfate Ophthalmic Solution 1 %</i>	T1	
ATROVENT HFA (<i>Ipratropium Bromide HFA</i>)	T1	
BREZTRI AEROSPHERE (<i>Budeson-Glycopyrrol-Formoterol</i>)	T1	PA
<i>chlordiazepOXIDE-Clidinium</i>	T1	
COMBIVENT RESPIMAT (<i>Ipratropium-Albuterol</i>)	T1	
<i>Dicyclomine HCl Intramuscular</i>	T1	PA
<i>Dicyclomine HCl Oral Capsule</i>	T1	
<i>Dicyclomine HCl Oral Tablet 20 MG</i>	T1	
<i>Diphenoxylate-Atropine Oral Liquid</i>	T1	
<i>Diphenoxylate-Atropine Oral Tablet 2.5-0.025 MG</i>	T1	
<i>Glycopyrrolate Oral Tablet 1 MG, 2 MG</i>	T1	
<i>HYDROcodone Bit-Homatrop MBr</i>	T1	QL (45 ML per 30 days); AL (Min 18 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Hydromet Oral Solution</i>	T1	QL (45 ML per 30 days); AL (Min 18 Years)
<i>Hyoscyamine Sulfate ER Oral Tablet Extended Release 12 Hour</i>	T1	
<i>Hyoscyamine Sulfate Oral</i>	T1	
<i>Hyoscyamine Sulfate Sublingual</i>	T1	
<i>Hyosyne</i>	T1	
INCRUSE ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5 MCG/ACT (<i>Umeclidinium Bromide</i>)	T1	QL (30 EA per 30 days)
<i>Ipratropium Bromide Inhalation</i>	T1	
<i>Ipratropium Bromide Nasal</i>	T1	
<i>Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML</i>	T1	
<i>Methscopolamine Bromide Oral Tablet 2.5 MG</i>	T1	PA
MOTOFEN (<i>Difenoxin-Atropine</i>)	T1	
NULEV (<i>Hyoscyamine Sulfate</i>)	T1	
<i>Oscimin Oral Tablet</i>	T1	
<i>Oscimin Sublingual</i>	T1	
<i>PB-Hyoscy-Atropine-Scopolamine</i>	T1	
<i>PHENobarbital-Belladonna Alk Oral Elixir</i>	T1	
PHENOHYTRO ORAL TABLET (<i>PB-Hyoscy-Atropine-Scopolamine</i>)	T1	
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 2.5 MCG/ACT (<i>Tiotropium Bromide</i>)	T1	QL (4 GM per 30 days)
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT (<i>Tiotropium Bromide-Olodaterol</i>)	T1	
<i>Tiotropium Bromide</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT <i>(Fluticasone-Umeclidin-Vilant)</i>	T1	PA
<i>Umeclidinium-Vilanterol</i>	T1	
Antiparkinsonian Agents		
<i>Benztropine Mesylate Oral</i>	T1	QL (120 EA per 30 days)
<i>diphenhydrAMINE HCl Oral Capsule 25 MG</i>	T1	
<i>diphenhydrAMINE HCl Oral Elixir</i>	T1	
<i>Trihexyphenidyl HCl</i>	T1	
Autonomic Drugs, Miscellaneous		
<i>CVS Nicotine Mouth/Throat Gum</i>	T1	QL (340 EA per 30 days)
<i>CVS Nicotine Mouth/Throat Lozenge</i>	T1	QL (324 EA per 30 days)
<i>CVS Nicotine Polacrilex Mouth/Throat Gum</i>	T1	QL (340 EA per 30 days)
<i>CVS Nicotine Polacrilex Mouth/Throat Lozenge</i>	T1	QL (324 EA per 30 days)
<i>CVS Nicotine Transdermal</i>	T1	QL (30 EA per 30 days)
<i>EQ Nicotine Mouth/Throat Lozenge</i>	T1	QL (324 EA per 30 days)
<i>EQ Nicotine Polacrilex Mouth/Throat Gum</i>	T1	QL (340 EA per 30 days)
<i>EQ Nicotine Polacrilex Mouth/Throat Lozenge</i>	T1	QL (324 EA per 30 days)
<i>EQ Nicotine Step 3</i>	T1	QL (30 EA per 30 days)
<i>EQ Nicotine Transdermal Patch 24 Hour 14 MG/24HR, 21 MG/24HR</i>	T1	QL (30 EA per 30 days)
<i>GNP Nicotine Mini</i>	T1	QL (324 EA per 30 days)
<i>GNP Nicotine Mouth/Throat Gum 4 MG</i>	T1	QL (340 EA per 30 days)
<i>GNP Nicotine Polacrilex Mouth/Throat Gum</i>	T1	QL (340 EA per 30 days)
<i>GNP Nicotine Polacrilex Mouth/Throat Lozenge</i>	T1	QL (324 EA per 30 days)
<i>GNP Nicotine Transdermal</i>	T1	QL (30 EA per 30 days)
<i>GoodSense Nicotine Mouth/Throat Gum</i>	T1	QL (340 EA per 30 days)
<i>GoodSense Nicotine Mouth/Throat Lozenge</i>	T1	QL (324 EA per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KLS QUIT2 MOUTH/THROAT LOZENGE (<i>Nicotine Polacrilex</i>)	T1	QL (324 EA per 30 days)
KLS QUIT4 MOUTH/THROAT LOZENGE (<i>Nicotine Polacrilex</i>)	T1	QL (324 EA per 30 days)
<i>Nicotine Mini</i>	T1	QL (324 EA per 30 days)
<i>Nicotine Polacrilex Mini</i>	T1	QL (324 EA per 30 days)
<i>Nicotine Polacrilex Mouth/Throat Gum</i>	T1	QL (340 EA per 30 days)
<i>Nicotine Polacrilex Mouth/Throat Lozenge</i>	T1	QL (324 EA per 30 days)
<i>Nicotine Step 1</i>	T1	QL (30 EA per 30 days)
<i>Nicotine Step 2</i>	T1	QL (30 EA per 30 days)
<i>Nicotine Step 3</i>	T1	QL (30 EA per 30 days)
<i>Nicotine Transdermal Patch 24 Hour</i>	T1	QL (30 EA per 30 days)
NICOTROL NS (<i>Nicotine</i>)	T1	PA
<i>QC Nicotine Transdermal System</i>	T1	QL (30 EA per 30 days)
<i>SM Nicotine Mouth/Throat Gum</i>	T1	QL (340 EA per 30 days)
<i>SM Nicotine Mouth/Throat Lozenge</i>	T1	QL (324 EA per 30 days)
<i>SM Nicotine Polacrilex Mouth/Throat Lozenge 4 MG</i>	T1	QL (324 EA per 30 days)
<i>Varenicline Tartrate (Starter)</i>	T1	QL (180 EA per 365 days)
<i>Varenicline Tartrate Oral Tablet 0.5 MG, 1 MG</i>	T1	QL (180 EA per 365 days)
Botulinum Toxins		
DYSPORT (<i>AbobotulinumtoxinA</i>)	T1	PA
XEOMIN (<i>IncobotulinumtoxinA</i>)	T1	PA
Centrally Acting Skeletal Muscle Relaxant		
<i>Chlorzoxazone Oral Tablet 250 MG, 500 MG</i>	T1	
<i>Cyclobenzaprine HCl Oral Tablet 10 MG, 5 MG</i>	T1	
<i>Metaxalone Oral Tablet 800 MG</i>	T1	PA
<i>Methocarbamol Oral Tablet 500 MG, 750 MG</i>	T1	
<i>tiZANidine HCl Oral Capsule 2 MG, 4 MG, 6 MG</i>	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>tiZANidine HCl Oral Tablet 2 MG</i>	T1	QL (540 EA per 30 days)
<i>tiZANidine HCl Oral Tablet 4 MG</i>	T1	QL (270 EA per 30 days)
Direct-Acting Skeletal Muscle Relaxants		
<i>Dantrolene Sodium Oral</i>	T1	
Gaba-Derivative Skeletal Muscle Relaxant		
<i>Baclofen Oral Tablet 10 MG, 20 MG</i>	T1	
<i>Baclofen Oral Tablet 5 MG</i>	T1	QL (90 EA per 30 days)
Indirect-Acting Skeletal Muscle Relaxant		
<i>Norgesic Forte</i>	T1	
<i>Orphenadrine Citrate Injection</i>	T1	
<i>Orphenadrine-Aspirin-Caffeine Oral Tablet 25-385-30 MG</i>	T1	
ORPHENGESIC FORTE ORAL TABLET 50-770-60 MG (<i>Orphenadrine-Aspirin-Caffeine</i>)	T1	
Non-Sel. Beta-Adrenergic Blocking Agents		
BETIMOL OPHTHALMIC SOLUTION 0.5 % (<i>Timolol Hemihydrate</i>)	T1	
<i>Carvedilol</i>	T1	
INNOPRAN XL (<i>Propranolol HCl SR Beads</i>)	T1	
<i>Labetalol HCl Oral</i>	T1	
<i>Nadolol Oral Tablet 20 MG, 40 MG, 80 MG</i>	T1	
<i>Pindolol</i>	T1	PA
<i>Propranolol HCl ER</i>	T1	
<i>Propranolol HCl Oral</i>	T1	
<i>Sotalol HCl (AF)</i>	T1	
<i>Sotalol HCl Oral</i>	T1	
<i>Timolol Maleate (Once-Daily)</i>	T1	
<i>Timolol Maleate</i> (Timolol Maleate OcuDose)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Timolol Maleate Ophthalmic</i>	T1	
<i>Timolol Maleate Oral</i>	T1	PA
<i>Timolol Maleate PF</i>	T1	
Non-Sel.Alpha-1-Adrenergic Blocking Agts		
<i>Doxazosin Mesylate Oral</i>	T1	
<i>Prazosin HCl Oral</i>	T1	
<i>Terazosin HCl Oral</i>	T1	
Non-Sel.Alpha-Adrenergic Blocking Agents		
<i>Dihydroergotamine Mesylate Injection</i>	T1	PA
<i>Ergotamine-Caffeine</i>	T1	
MIGERGOT (<i>Ergotamine-Caffeine</i>)	T1	
<i>Phenoxybenzamine HCl Oral</i>	T1	
Parasympathomimetic (Cholinergic Agents)		
<i>Bethanechol Chloride Oral Tablet 10 MG, 25 MG, 5 MG</i>	T1	
<i>Bethanechol Chloride Oral Tablet 50 MG</i>	T1	PA
<i>Cevimeline HCl</i>	T1	
<i>Donepezil HCl Oral Tablet 10 MG, 5 MG</i>	T1	
<i>Donepezil HCl Oral Tablet 23 MG</i>	T1	PA
<i>Donepezil HCl Oral Tablet Dispersible</i>	T1	
<i>Neostigmine Methylsulfate Intravenous Solution Prefilled Syringe 3 MG/3ML</i>	T1	PA
<i>Pilocarpine HCl Ophthalmic Solution 1 %, 2 %, 4 %</i>	T1	
<i>Pilocarpine HCl Oral Tablet 5 MG</i>	T1	
<i>Pilocarpine HCl Oral Tablet 7.5 MG</i>	T1	PA
<i>Pyridostigmine Bromide ER Oral Tablet Extended Release</i>	T1	
<i>pyRIDostigmine Bromide Oral Tablet 60 MG</i>	T1	
<i>Rivastigmine Tartrate</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Selective Alpha-1-Adrenergic Block.Agent		
<i>Alfuzosin HCl ER</i>	T1	
<i>Carvedilol</i>	T1	
<i>Labetalol HCl Oral</i>	T1	
<i>Tamsulosin HCl</i>	T1	
Selective Beta-2-Adrenergic Agonists		
<i>Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT</i>	T1	QL (36 GM per 30 days)
<i>Albuterol Sulfate Inhalation Nebulization Solution (2.5 MG/3ML) 0.083%, (5 MG/ML) 0.5%, 2.5 MG/0.5ML</i>	T1	
<i>Albuterol Sulfate Inhalation Nebulization Solution 0.63 MG/3ML, 1.25 MG/3ML</i>	T1	PA
<i>Albuterol Sulfate Oral Syrup 2 MG/5ML</i>	T1	
<i>Albuterol Sulfate Oral Tablet</i>	T1	
<i>BREZTRI AEROSPHERE (Budeson-Glycopyrrol-Formoterol)</i>	T1	PA
<i>Budesonide-Formoterol Fumarate</i>	T1	QL (20.4 GM per 30 days)
<i>COMBIVENT RESPIMAT (Ipratropium-Albuterol)</i>	T1	
<i>DULERA (Mometasone Furo-Formoterol Fum)</i>	T1	
<i>Fluticasone Furoate-Vilanterol Inhalation Aerosol Powder Breath Activated 100-25 MCG/ACT, 200-25 MCG/ACT</i>	T1	
<i>Fluticasone-Salmeterol Inhalation Aerosol</i>	T1	PA
<i>Fluticasone-Salmeterol Inhalation Aerosol Powder Breath Activated 100-50 MCG/ACT, 113-14 MCG/ACT, 232-14 MCG/ACT, 250-50 MCG/ACT, 500-50 MCG/ACT, 55-14 MCG/ACT</i>	T1	
<i>Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Levalbuterol HCl Inhalation Nebulization Solution 0.31 MG/3ML, 0.63 MG/3ML, 1.25 MG/0.5ML, 1.25 MG/3ML</i>	T1	PA
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (<i>Salmeterol Xinafoate</i>)	T1	
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT (<i>Tiotropium Bromide-Olodaterol</i>)	T1	
<i>Terbutaline Sulfate Oral</i>	T1	
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT (<i>Fluticasone-Umeclidin-Vilant</i>)	T1	PA
<i>Umeclidinium-Vilanterol</i>	T1	
<i>Fluticasone-Salmeterol</i> (Wixela Inhub Inhalation Aerosol Powder Breath Activated 100-50 Mcg/Act, 250-50 Mcg/Act, 500-50 Mcg/Act)	T1	
Selective Beta-Adrenergic Blocking Agent		
<i>Acebutolol HCl Oral</i>	T1	
<i>Atenolol Oral</i>	T1	
<i>Atenolol-Chlorthalidone</i>	T1	
<i>Betaxolol HCl</i>	T1	PA
BETOPTIC-S (<i>Betaxolol HCl</i>)	T1	PA
<i>Bisoprolol Fumarate Oral Tablet 10 MG, 5 MG</i>	T1	
<i>Bisoprolol-hydroCHLOROthiazide</i>	T1	
<i>Metoprolol Succinate ER</i>	T1	
<i>Metoprolol Tartrate Oral Tablet 100 MG, 25 MG, 50 MG</i>	T1	
<i>Metoprolol-hydroCHLOROthiazide</i>	T1	PA
<i>Nadolol Oral Tablet 20 MG, 40 MG, 80 MG</i>	T1	
Skeletal Muscle Relaxants, Miscellaneous		
DYSPORT (<i>AbobotulinumtoxinA</i>)	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Norgesic Forte</i>	T1	
<i>Orphenadrine Citrate Injection</i>	T1	
<i>Orphenadrine-Aspirin-Caffeine Oral Tablet 25-385-30 MG</i>	T1	
ORPHENGESIC FORTE ORAL TABLET 50-770-60 MG (<i>Orphenadrine-Aspirin-Caffeine</i>)	T1	
XEOMIN (<i>IncobotulinumtoxinA</i>)	T1	PA
Smoking Cessation Agents		
<i>buPROPion HCl ER (Smoking Det)</i>	T1	QL (60 EA per 30 days)
<i>CVS Nicotine Mouth/Throat Gum</i>	T1	QL (340 EA per 30 days)
<i>CVS Nicotine Mouth/Throat Lozenge</i>	T1	QL (324 EA per 30 days)
<i>CVS Nicotine Polacrilex Mouth/Throat Gum</i>	T1	QL (340 EA per 30 days)
<i>CVS Nicotine Polacrilex Mouth/Throat Lozenge</i>	T1	QL (324 EA per 30 days)
<i>CVS Nicotine Transdermal</i>	T1	QL (30 EA per 30 days)
<i>EQ Nicotine Mouth/Throat Lozenge</i>	T1	QL (324 EA per 30 days)
<i>EQ Nicotine Polacrilex Mouth/Throat Gum</i>	T1	QL (340 EA per 30 days)
<i>EQ Nicotine Polacrilex Mouth/Throat Lozenge</i>	T1	QL (324 EA per 30 days)
<i>EQ Nicotine Step 3</i>	T1	QL (30 EA per 30 days)
<i>EQ Nicotine Transdermal Patch 24 Hour 14 MG/24HR, 21 MG/24HR</i>	T1	QL (30 EA per 30 days)
<i>GNP Nicotine Mini</i>	T1	QL (324 EA per 30 days)
<i>GNP Nicotine Mouth/Throat Gum 4 MG</i>	T1	QL (340 EA per 30 days)
<i>GNP Nicotine Polacrilex Mouth/Throat Gum</i>	T1	QL (340 EA per 30 days)
<i>GNP Nicotine Polacrilex Mouth/Throat Lozenge</i>	T1	QL (324 EA per 30 days)
<i>GNP Nicotine Transdermal</i>	T1	QL (30 EA per 30 days)
<i>GoodSense Nicotine Mouth/Throat Gum</i>	T1	QL (340 EA per 30 days)
<i>GoodSense Nicotine Mouth/Throat Lozenge</i>	T1	QL (324 EA per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KLS QUIT2 MOUTH/THROAT LOZENGE (<i>Nicotine Polacrilex</i>)	T1	QL (324 EA per 30 days)
KLS QUIT4 MOUTH/THROAT LOZENGE (<i>Nicotine Polacrilex</i>)	T1	QL (324 EA per 30 days)
<i>Naltrexone HCl Oral</i>	T1	
<i>Nicotine Mini</i>	T1	QL (324 EA per 30 days)
<i>Nicotine Polacrilex Mini</i>	T1	QL (324 EA per 30 days)
<i>Nicotine Polacrilex Mouth/Throat Gum</i>	T1	QL (340 EA per 30 days)
<i>Nicotine Polacrilex Mouth/Throat Lozenge</i>	T1	QL (324 EA per 30 days)
<i>Nicotine Step 1</i>	T1	QL (30 EA per 30 days)
<i>Nicotine Step 2</i>	T1	QL (30 EA per 30 days)
<i>Nicotine Step 3</i>	T1	QL (30 EA per 30 days)
<i>Nicotine Transdermal Patch 24 Hour</i>	T1	QL (30 EA per 30 days)
NICOTROL NS (<i>Nicotine</i>)	T1	PA
<i>QC Nicotine Transdermal System</i>	T1	QL (30 EA per 30 days)
<i>SM Nicotine Mouth/Throat Gum</i>	T1	QL (340 EA per 30 days)
<i>SM Nicotine Mouth/Throat Lozenge</i>	T1	QL (324 EA per 30 days)
<i>SM Nicotine Polacrilex Mouth/Throat Lozenge 4 MG</i>	T1	QL (324 EA per 30 days)
TYRVAYA (<i>Varenicline Tartrate</i>)	T1	PA
<i>Varenicline Tartrate (Starter)</i>	T1	QL (180 EA per 365 days)
<i>Varenicline Tartrate Oral Tablet 0.5 MG, 1 MG</i>	T1	QL (180 EA per 365 days)
VIVITROL (<i>Naltrexone</i>)	T1	
Blood Formation, Coagulation, Thrombosis		
Antianemia Drugs		
EPOGEN INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML (<i>Epoetin Alfa</i>)	T1	PA
PROCRIT (<i>Epoetin Alfa</i>)	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RETACRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML (<i>Epoetin Alfa-epbx</i>)	T1	PA
Anticoagulants, Miscellaneous		
ACD-A NOCLOT-50 (<i>Anticoagulant Cit Dext Soln A</i>)	T1	
<i>Fondaparinux Sodium</i>	T1	
Antithrombotic Agents, Miscellaneous		
LODOCO (<i>Colchicine</i>)	T1	PA
Coumarin Derivatives		
<i>Warfarin Sodium</i> (Jantoven)	T1	
<i>Warfarin Sodium Oral</i>	T1	
Direct Factor Xa Inhibitors		
ELIQUIS (1.5 MG PACK) (<i>Apixaban</i>)	T1	
ELIQUIS (2 MG PACK) (<i>Apixaban</i>)	T1	
ELIQUIS DVT/PE STARTER PACK ORAL TABLET THERAPY PACK (<i>Apixaban</i>)	T1	QL (74 EA per 30 days)
ELIQUIS ORAL CAPSULE SPRINKLE (<i>Apixaban</i>)	T1	QL (74 EA per 30 days)
ELIQUIS ORAL TABLET (<i>Apixaban</i>)	T1	QL (60 EA per 30 days)
ELIQUIS ORAL TABLET SOLUBLE (<i>Apixaban</i>)	T1	
<i>Fondaparinux Sodium</i>	T1	
XARELTO ORAL SUSPENSION RECONSTITUTED (<i>Rivaroxaban</i>)	T1	QL (600 ML per 30 days)
XARELTO ORAL TABLET 10 MG, 20 MG (<i>Rivaroxaban</i>)	T1	QL (30 EA per 30 days)
XARELTO ORAL TABLET 15 MG (<i>Rivaroxaban</i>)	T1	QL (42 EA per 21 days)
XARELTO ORAL TABLET 2.5 MG (<i>Rivaroxaban</i>)	T1	QL (60 EA per 30 days)
XARELTO STARTER PACK (<i>Rivaroxaban</i>)	T1	QL (51 EA per 30 days)
Direct Thrombin Inhibitors		
<i>Dabigatran Etexilate Mesylate</i>	T1	QL (60 EA per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Hematopoietic Agents		
EPOGEN INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML (<i>Epoetin Alfa</i>)	T1	PA
FULPHILA (<i>Pegfilgrastim-jmdb</i>)	T1	PA
FYLNETRA (<i>Pegfilgrastim-pbbk</i>)	T1	PA
GRANIX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>Tbo-Filgrastim</i>)	T1	PA
NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>Pegfilgrastim</i>)	T1	PA
NEUPOGEN INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6ML (<i>Filgrastim</i>)	T1	PA
NEUPOGEN INJECTION SOLUTION PREFILLED SYRINGE (<i>Filgrastim</i>)	T1	PA
NIVESTYM (<i>Filgrastim-aafi</i>)	T1	PA
NYPOZI (<i>Filgrastim-txid</i>)	T1	PA
NYVEPRIA (<i>Pegfilgrastim-apgf</i>)	T1	PA
PROCRIT (<i>Epoetin Alfa</i>)	T1	PA
<i>Releuko Subcutaneous</i>	T1	PA
RETACRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML (<i>Epoetin Alfa-epbx</i>)	T1	PA
STIMUFEND (<i>Pegfilgrastim-fpgk</i>)	T1	PA
UDENYCA (<i>Pegfilgrastim-cbqv</i>)	T1	PA
UDENYCA ONBODY (<i>Pegfilgrastim-cbqv</i>)	T1	PA
ZARXIO (<i>Filgrastim-sndz</i>)	T1	PA
ZIEXTENZO (<i>Pegfilgrastim-bmez</i>)	T1	PA
Hemorrhologic Agents		
<i>Pentoxifylline ER</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Hemostatics		
<i>Aminocaproic Acid Oral Solution</i>	T1	PA
<i>Aminocaproic Acid Oral Tablet 1000 MG</i>	T1	
<i>Aminocaproic Acid Oral Tablet 500 MG</i>	T1	PA
<i>Desmopressin Ace Spray Refrig</i>	T1	PA
<i>Desmopressin Acetate Injection</i>	T1	PA
<i>Desmopressin Acetate Nasal</i>	T1	PA
<i>Desmopressin Acetate Oral</i>	T1	
<i>Desmopressin Acetate PF</i>	T1	PA
<i>Desmopressin Acetate Spray</i>	T1	PA
GELFILM OPHTHALMIC (<i>Gelatin Adsorbable</i>)	T1	PA
Heparins		
<i>Enoxaparin Sodium Injection Solution 300 MG/3ML</i>	T1	
<i>Enoxaparin Sodium Injection Solution Prefilled Syringe 100 MG/ML, 150 MG/ML</i>	T1	QL (40 ML per 180 days)
<i>Enoxaparin Sodium Injection Solution Prefilled Syringe 120 MG/0.8ML, 80 MG/0.8ML</i>	T1	QL (32 ML per 180 days)
<i>Enoxaparin Sodium Injection Solution Prefilled Syringe 30 MG/0.3ML</i>	T1	QL (12 ML per 180 days)
<i>Enoxaparin Sodium Injection Solution Prefilled Syringe 40 MG/0.4ML</i>	T1	QL (16 ML per 180 days)
<i>Enoxaparin Sodium Injection Solution Prefilled Syringe 60 MG/0.6ML</i>	T1	QL (24 ML per 180 days)
FRAGMIN SUBCUTANEOUS SOLUTION 95000 UNIT/3.8ML (<i>Dalteparin Sodium</i>)	T1	
<i>Heparin Na (Pork) Lock Flush Intravenous Solution 10 UNIT/ML</i>	T1	
<i>Heparin Sod (Pork) Lock Flush Intravenous Solution 10 UNIT/ML, 100 UNIT/ML</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Heparin Sodium (Porcine) Injection Solution 1000 UNIT/ML, 10000 UNIT/ML, 20000 UNIT/ML, 5000 UNIT/ML</i>	T1	
<i>Heparin Sodium (Porcine) PF Injection Solution 1000 UNIT/ML</i>	T1	
Indirect Factor Xa Inhibitors		
<i>Fondaparinux Sodium</i>	T1	
Iron Preparations		
<i>Classic Prenatal</i>	T1	
<i>Complete Natal DHA Oral 29-1-200 & 200 MG</i>	T1	
<i>ELITE-OB (Prenatal Vit-Iron Carbonyl-FA)</i>	T1	
<i>EQL Prenatal Formula</i>	T1	
<i>GERITOL TONIC (Iron-Vitamins)</i>	T1	
<i>GNP PreNatal</i>	T1	
<i>Hematinic Plus Vit/Minerals</i>	T1	
<i>Hematinic/Folic Acid</i>	T1	
<i>HEMATOGEN FA (Fe Fum-Vit C-Vit B12-FA)</i>	T1	
<i>INFED (Iron Dextran)</i>	T1	
<i>M-Natal Plus</i>	T1	
<i>Multiple Vitamins-Iron Oral Tablet Chewable</i>	T1	
<i>Multivitamin Adult Oral Tablet</i>	T1	
<i>Multivitamin Oral Tablet</i>	T1	
<i>NUTRIVIT (B Complex-Lysine-Min-Fe-FA)</i>	T1	
<i>Poly-Iron 150 Forte</i>	T1	
<i>PRENATAL MULTIVITAMIN + DHA (Prenatal MV-Min-Fe Fum-FA-DHA)</i>	T1	
<i>Prenatal One Daily</i>	T1	
<i>Prenatal Oral Tablet 27-0.8 MG, 27-1 MG, 28-0.8 MG</i>	T1	
<i>Prenatal Plus</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Prenatal Vitamin and Mineral</i>	T1	
<i>Prenatal Vitamins Oral Tablet 28-0.8 MG</i>	T1	
<i>Prenatal/Iron</i>	T1	
<i>QC Prenatal</i>	T1	
<i>Thrivite Rx</i>	T1	
<i>Trigels-F Forte</i>	T1	
VITALETS CHILDRENS ORAL TABLET CHEWABLE (<i>Pediatric Multivit-Minerals</i>)	T1	
<i>WesTab Plus</i>	T1	
Liver And Stomach Preparations		
B-12 DOTS (<i>Cyanocobalamin</i>)	T1	
<i>B-12 Oral Tablet 100 MCG, 50 MCG, 500 MCG</i>	T1	
<i>B-12 TR Oral Tablet Extended Release 2000 MCG</i>	T1	
<i>CVS B-12 Oral Tablet</i>	T1	
<i>CVS Vitamin B-12 Oral Tablet Extended Release</i>	T1	
<i>Cyanocobalamin Injection Solution 1000 MCG/ML</i>	T1	
<i>EQL Vitamin B-12</i>	T1	
<i>GNP Vitamin B-12 Oral Tablet</i>	T1	
<i>Hydroxocobalamin Acetate</i>	T1	
<i>Neurin-SL</i>	T1	
<i>Vitamin B 12 Oral Tablet</i>	T1	
<i>Vitamin B-12 ER Oral Tablet Extended Release 2000 MCG</i>	T1	
<i>Vitamin B12 TR Oral Tablet Extended Release 2000 MCG</i>	T1	
Platelet-Aggregation Inhibitors		
<i>Aspirin 81</i>	T1	
<i>Aspirin Adult Low Dose</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Aspirin Adult Low Strength Oral Tablet Delayed Release</i>	T1	
<i>Aspirin Childrens</i>	T1	
<i>Aspirin EC Adult Low Dose</i>	T1	
<i>Aspirin EC Low Dose</i>	T1	
<i>Aspirin EC Low Strength</i>	T1	
<i>Aspirin Low Dose Oral Tablet Chewable</i>	T1	
<i>Aspirin Low Dose Oral Tablet Delayed Release</i>	T1	
<i>Aspirin Low Strength</i>	T1	
<i>Aspirin Oral Tablet Chewable</i>	T1	
<i>Aspirin Oral Tablet Delayed Release 81 MG</i>	T1	
<i>Aspirin Regimen</i>	T1	
<i>Aspirin-Dipyridamole ER</i>	T1	
BAYER ASPIRIN EC LOW DOSE (<i>Aspirin</i>)	T1	
BAYER LOW DOSE ORAL TABLET DELAYED RELEASE (<i>Aspirin</i>)	T1	
<i>Butalbital-Aspirin-Caffeine Oral Capsule</i>	T1	
<i>Childrens Aspirin</i>	T1	
<i>Cilostazol</i>	T1	
<i>Clopidogrel Bisulfate Oral Tablet 300 MG</i>	T1	QL (2 EA per 30 days)
<i>Clopidogrel Bisulfate Oral Tablet 75 MG</i>	T1	
<i>CVS Aspirin Adult Low Dose</i>	T1	
<i>CVS Aspirin EC Oral Tablet Delayed Release 81 MG</i>	T1	
<i>CVS Aspirin Low Dose</i>	T1	
<i>CVS Aspirin Low Strength Oral Tablet Delayed Release</i>	T1	
<i>Dipyridamole Oral</i>	T1	
ECOTRIN LOW STRENGTH (<i>Aspirin</i>)	T1	
<i>EQ Aspirin Adult Low Dose</i>	T1	
<i>EQ Aspirin Low Dose Oral Tablet Chewable</i>	T1	

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bold italics = Generic drugs UPPERCASE = Brand name drugs	Drug Tier	Coverage Requirements and Limits
	SCO = State Carve Out T1 = Preferred Medication T2 = Preferred Medication with Restriction T3 = Non-Preferred Medication - Prior Authorization is Required	AL = Age Limit PA = Prior Authorization QL = Quantity Limit SCO = State Carve Out ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>EQL Aspirin Low Dose</i>	T1	
<i>GNP Adult Aspirin Low Strength Oral Tablet Chewable</i>	T1	
<i>GNP Aspirin Low Dose</i>	T1	
<i>GNP Aspirin Oral Tablet Delayed Release 81 MG</i>	T1	
<i>GoodSense Aspirin Low Dose</i>	T1	
<i>GoodSense Aspirin Oral Tablet Chewable</i>	T1	
MEDIQUE ASPIRIN (<i>Aspirin</i>)	T1	
<i>MM Aspirin Oral Tablet Delayed Release</i>	T1	
<i>Prasugrel HCl</i>	T1	QL (30 EA per 30 days)
<i>QC Aspirin Low Dose</i>	T1	
<i>Ticagrelor</i>	T1	QL (60 EA per 30 days)
Platelet-Reducing Agents		
<i>Anagrelide HCl Oral Capsule 0.5 MG</i>	T1	
Thrombolytic Agents		
<i>Aspirin 81</i>	T1	
<i>Aspirin Adult Low Dose</i>	T1	
<i>Aspirin Adult Low Strength Oral Tablet Delayed Release</i>	T1	
<i>Aspirin Childrens</i>	T1	
<i>Aspirin EC Adult Low Dose</i>	T1	
<i>Aspirin EC Low Dose</i>	T1	
<i>Aspirin EC Low Strength</i>	T1	
<i>Aspirin Low Dose Oral Tablet Chewable</i>	T1	
<i>Aspirin Low Dose Oral Tablet Delayed Release</i>	T1	
<i>Aspirin Low Strength</i>	T1	
<i>Aspirin Oral Tablet Chewable</i>	T1	
<i>Aspirin Oral Tablet Delayed Release 81 MG</i>	T1	
<i>Aspirin Regimen</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BAYER ASPIRIN EC LOW DOSE (<i>Aspirin</i>)	T1	
BAYER LOW DOSE ORAL TABLET DELAYED RELEASE (<i>Aspirin</i>)	T1	
<i>Butalbital-Aspirin-Caffeine Oral Capsule</i>	T1	
<i>Childrens Aspirin</i>	T1	
<i>CVS Aspirin Adult Low Dose</i>	T1	
<i>CVS Aspirin EC Oral Tablet Delayed Release 81 MG</i>	T1	
<i>CVS Aspirin Low Dose</i>	T1	
<i>CVS Aspirin Low Strength Oral Tablet Delayed Release</i>	T1	
ECOTRIN LOW STRENGTH (<i>Aspirin</i>)	T1	
<i>EQ Aspirin Adult Low Dose</i>	T1	
<i>EQ Aspirin Low Dose Oral Tablet Chewable</i>	T1	
<i>EQL Aspirin Low Dose</i>	T1	
<i>GNP Adult Aspirin Low Strength Oral Tablet Chewable</i>	T1	
<i>GNP Aspirin Low Dose</i>	T1	
<i>GNP Aspirin Oral Tablet Delayed Release 81 MG</i>	T1	
<i>GoodSense Aspirin Low Dose</i>	T1	
<i>GoodSense Aspirin Oral Tablet Chewable</i>	T1	
MEDIQUE ASPIRIN (<i>Aspirin</i>)	T1	
<i>MM Aspirin Oral Tablet Delayed Release</i>	T1	
<i>QC Aspirin Low Dose</i>	T1	
Cardiovascular Drugs		
AcI Inhibitors		
NEXLETOL (<i>Bempedoic Acid</i>)	T1	PA
NEXLIZET (<i>Bempedoic Acid-Ezetimibe</i>)	T1	PA
Alpha-Adrenergic Blocking Agents (24:16)		
<i>Doxazosin Mesylate Oral</i>	T1	
<i>Nadolol Oral Tablet 20 MG, 40 MG, 80 MG</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Prazosin HCl Oral</i>	T1	
<i>Terazosin HCl Oral</i>	T1	
Alpha-Adrenergic Blocking Agt.(Hypoten)		
<i>Carvedilol</i>	T1	
<i>Doxazosin Mesylate Oral</i>	T1	
<i>Labetalol HCl Oral Tablet 100 MG, 200 MG, 300 MG</i>	T1	
<i>Prazosin HCl Oral</i>	T1	
<i>Terazosin HCl Oral</i>	T1	
Angiotensin li Recep Antagonist/Neprolys		
ENTRESTO ORAL CAPSULE SPRINKLE (<i>Sacubitril-Valsartan</i>)	T1	QL (240 EA per 30 days)
<i>Sacubitril-Valsartan</i>	T1	QL (60 EA per 30 days)
Angiotensin li Receptor Antagon.(Hypotn)		
<i>Candesartan Cilexetil</i>	T1	PA
<i>Candesartan Cilexetil-HCTZ Oral Tablet 16-12.5 MG, 32-12.5 MG</i>	T1	PA
<i>Irbesartan</i>	T1	
<i>Irbesartan-hydroCHLOROthiazide</i>	T1	
<i>Losartan Potassium Oral</i>	T1	
<i>Losartan Potassium-HCTZ</i>	T1	
<i>Olmesartan Medoxomil Oral</i>	T1	
<i>Olmesartan Medoxomil-HCTZ</i>	T1	
<i>Telmisartan</i>	T1	
<i>Telmisartan-HCTZ</i>	T1	PA
<i>Valsartan Oral Tablet</i>	T1	
<i>Valsartan-hydroCHLOROthiazide</i>	T1	
Angiotensin li Receptor Antagonists		
<i>Candesartan Cilexetil</i>	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Candesartan Cilexetil-HCTZ Oral Tablet 16-12.5 MG, 32-12.5 MG</i>	T1	PA
ENTRESTO ORAL CAPSULE SPRINKLE (<i>Sacubitril-Valsartan</i>)	T1	QL (240 EA per 30 days)
<i>Irbesartan</i>	T1	
<i>Irbesartan-hydroCHLOROthiazide</i>	T1	
<i>Losartan Potassium Oral</i>	T1	
<i>Losartan Potassium-HCTZ</i>	T1	
<i>Olmesartan Medoxomil Oral</i>	T1	
<i>Olmesartan Medoxomil-HCTZ</i>	T1	
<i>Sacubitril-Valsartan</i>	T1	QL (60 EA per 30 days)
<i>Telmisartan</i>	T1	
<i>Telmisartan-HCTZ</i>	T1	PA
<i>Valsartan Oral Tablet</i>	T1	
<i>Valsartan-hydroCHLOROthiazide</i>	T1	
Angiotensin-Convert.Enzyme Inhib(Hypotn)		
<i>amLODIPine Besy-Benazepril HCl</i>	T1	
<i>Benazepril HCl Oral</i>	T1	
<i>Benazepril-hydroCHLOROthiazide</i>	T1	
<i>Captopril Oral</i>	T1	
<i>Captopril-hydroCHLOROthiazide</i>	T1	PA
<i>Enalapril Maleate Oral Tablet</i>	T1	
<i>Enalapril-Hydrochlorothiazide Oral Tablet 10-25 MG</i>	T1	
<i>Enalapril-Hydrochlorothiazide Oral Tablet 5-12.5 MG</i>	T1	PA
<i>Fosinopril Sodium</i>	T1	
<i>Fosinopril Sodium-HCTZ</i>	T1	PA
<i>Lisinopril Oral</i>	T1	
<i>Lisinopril-hydroCHLOROthiazide</i>	T1	

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	SCO = State Carve Out T1 = Preferred Medication T2 = Preferred Medication with Restriction T3 = Non-Preferred Medication - Prior Authorization is Required	AL = Age Limit PA = Prior Authorization QL = Quantity Limit SCO = State Carve Out ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Perindopril Erbumine</i>	T1	PA
<i>Quinapril HCl</i>	T1	
<i>Quinapril-hydroCHLOROthiazide</i>	T1	
<i>Ramipril</i>	T1	
<i>Trandolapril</i>	T1	
Angiotensin-Converting Enzyme Inhibitors		
<i>amLODIPine Besy-Benazepril HCl</i>	T1	
<i>Benazepril HCl Oral</i>	T1	
<i>Benazepril-hydroCHLOROthiazide</i>	T1	
<i>Captopril Oral</i>	T1	
<i>Captopril-hydroCHLOROthiazide</i>	T1	PA
<i>Enalapril Maleate Oral Tablet</i>	T1	
<i>Enalapril-Hydrochlorothiazide Oral Tablet 10-25 MG</i>	T1	
<i>Enalapril-Hydrochlorothiazide Oral Tablet 5-12.5 MG</i>	T1	PA
<i>Fosinopril Sodium</i>	T1	
<i>Fosinopril Sodium-HCTZ</i>	T1	PA
<i>Lisinopril Oral</i>	T1	
<i>Lisinopril-hydroCHLOROthiazide</i>	T1	
<i>Perindopril Erbumine</i>	T1	PA
<i>Quinapril HCl</i>	T1	
<i>Quinapril-hydroCHLOROthiazide</i>	T1	
<i>Ramipril</i>	T1	
<i>Trandolapril</i>	T1	
Antiarrhythmics, Miscellaneous		
<i>Digoxin (Digox)</i>	T1	
<i>Digoxin Oral Solution</i>	T1	
<i>Digoxin Oral Tablet 125 MCG, 250 MCG</i>	T1	

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bold italics = Generic drugs UPPERCASE = Brand name drugs	Drug Tier	Coverage Requirements and Limits
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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LANOXIN ORAL TABLET 125 MCG, 250 MCG (<i>Digoxin</i>)	T1	
<i>Magnesium Sulfate Injection Solution 50 %</i>	T1	
Antilipemic Agents, Miscellaneous		
<i>BP Vit 3</i>	T1	
ENDUR-ACIN ORAL TABLET EXTENDED RELEASE 500 MG (<i>Niacin</i>)	T1	
NEXLETOL (<i>Bempedoic Acid</i>)	T1	PA
NEXLIZET (<i>Bempedoic Acid-Ezetimibe</i>)	T1	PA
<i>Niacin (Antihyperlipidemic)</i>	T1	
<i>Niacin ER (Antihyperlipidemic)</i>	T1	PA
NIAVASC (<i>Niacin</i>)	T1	
<i>Omega-3-acid Ethyl Esters</i>	T1	ST
REPATHA (<i>Evolocumab</i>)	T1	PA
REPATHA SURECLICK (<i>Evolocumab</i>)	T1	PA
Beta-Adrenergic Blocking Agents (24:20)		
<i>Acebutolol HCl Oral</i>	T1	
<i>Atenolol Oral</i>	T1	
<i>Atenolol-Chlorthalidone</i>	T1	
<i>Betaxolol HCl Oral</i>	T1	PA
BETIMOL OPHTHALMIC SOLUTION 0.5 % (<i>Timolol Hemihydrate</i>)	T1	
<i>Bisoprolol Fumarate Oral Tablet 10 MG, 5 MG</i>	T1	
<i>Bisoprolol-hydroCHLOROthiazide</i>	T1	
<i>Carvedilol</i>	T1	
<i>Doxazosin Mesylate Oral</i>	T1	
INNOPRAN XL (<i>Propranolol HCl SR Beads</i>)	T1	
<i>Labetalol HCl Oral</i>	T1	
<i>Metoprolol Succinate ER</i>	T1	

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Drug Tier
SCO = State Carve Out
T1 = Preferred Medication
T2 = Preferred Medication with Restriction
T3 = Non-Preferred Medication - Prior Authorization is Required

Coverage Requirements and Limits
AL = Age Limit
PA = Prior Authorization
QL = Quantity Limit
SCO = State Carve Out
ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Metoprolol Tartrate Oral Tablet 100 MG, 25 MG, 50 MG</i>	T1	
<i>Metoprolol-hydroCHLOROthiazide</i>	T1	PA
<i>Nadolol Oral Tablet 20 MG, 40 MG, 80 MG</i>	T1	
<i>Pindolol</i>	T1	PA
<i>Prazosin HCl Oral</i>	T1	
<i>Propranolol HCl ER</i>	T1	
<i>Propranolol HCl Oral</i>	T1	
<i>Sotalol HCl (AF)</i>	T1	
<i>Sotalol HCl Oral</i>	T1	
<i>Terazosin HCl Oral</i>	T1	
<i>Timolol Maleate (Once-Daily)</i>	T1	
<i>Timolol Maleate</i> (Timolol Maleate OcuDose)	T1	
<i>Timolol Maleate Ophthalmic</i>	T1	
<i>Timolol Maleate Oral</i>	T1	PA
<i>Timolol Maleate PF</i>	T1	
Bile Acid Sequestrants		
<i>Cholestyramine Light</i>	T1	
<i>Cholestyramine Oral</i>	T1	
<i>Colestipol HCl</i>	T1	
<i>Cholestyramine Light</i> (Prevalite)	T1	
Calcium-Channel Block.Agt,Misc(Hypoten)		
<i>Diltiazem HCl Coated Beads</i> (Cartia Xt Oral Capsule Extended Release 24 Hour 180 Mg, 240 Mg, 300 Mg)	T1	
<i>Diltiazem HCl ER Beads Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG, 300 MG, 360 MG</i>	T1	
<i>Diltiazem HCl ER Beads Oral Capsule Extended Release 24 Hour 420 MG</i>	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>diltiazem HCl ER Coated Beads Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG, 300 MG</i>	T1	
<i>diltiazem HCl ER Coated Beads Oral Capsule Extended Release 24 Hour 360 MG</i>	T1	PA
<i>diltiazem HCl ER Oral Capsule Extended Release 12 Hour</i>	T1	ST
<i>diltiazem HCl ER Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG</i>	T1	
<i>diltiazem HCl ER Oral Tablet Extended Release 24 Hour</i>	T1	PA
<i>diltiazem HCl Oral</i>	T1	
<i>Dilt-XR</i>	T1	
<i>Diltiazem HCl</i> (Matzim La)	T1	PA
<i>Diltiazem HCl ER Beads</i> (Tiadyt Er Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg)	T1	
<i>Diltiazem HCl ER Beads</i> (Tiadyt Er Oral Capsule Extended Release 24 Hour 420 Mg)	T1	PA
<i>Verapamil HCl ER Oral Capsule Extended Release 24 Hour 100 MG, 200 MG, 300 MG, 360 MG</i>	T1	PA
<i>Verapamil HCl ER Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG</i>	T1	
<i>Verapamil HCl ER Oral Tablet Extended Release 120 MG, 180 MG, 240 MG</i>	T1	
<i>Verapamil HCl Oral</i>	T1	
Calcium-Channel Blocking Agents		
<i>amlodipine Besy-Benazepril HCl</i>	T1	
<i>amlodipine Besylate Oral</i>	T1	
<i>Diltiazem HCl Coated Beads</i> (Cartia Xt Oral Capsule Extended Release 24 Hour 180 Mg, 240 Mg, 300 Mg)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Diltiazem HCl ER Beads Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG, 300 MG, 360 MG</i>	T1	
<i>Diltiazem HCl ER Beads Oral Capsule Extended Release 24 Hour 420 MG</i>	T1	PA
<i>dilTIAZem HCl ER Coated Beads Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG, 300 MG</i>	T1	
<i>dilTIAZem HCl ER Coated Beads Oral Capsule Extended Release 24 Hour 360 MG</i>	T1	PA
<i>dilTIAZem HCl ER Oral Capsule Extended Release 12 Hour</i>	T1	ST
<i>dilTIAZem HCl ER Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG</i>	T1	
<i>dilTIAZem HCl ER Oral Tablet Extended Release 24 Hour</i>	T1	PA
<i>dilTIAZem HCl Oral</i>	T1	
<i>Dilt-XR</i>	T1	
<i>Felodipine ER</i>	T1	
<i>Isradipine</i>	T1	ST
<i>Diltiazem HCl (Matzim La)</i>	T1	PA
<i>niCARDipine HCl Oral</i>	T1	PA
<i>NIFEdipine ER</i>	T1	
<i>NIFEdipine ER Osmotic Release</i>	T1	
<i>NIFEdipine Oral</i>	T1	
<i>niMODipine Oral Capsule</i>	T1	PA
<i>Diltiazem HCl ER Beads (Tiadyt Er Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg)</i>	T1	
<i>Diltiazem HCl ER Beads (Tiadyt Er Oral Capsule Extended Release 24 Hour 420 Mg)</i>	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Verapamil HCl ER Oral Capsule Extended Release 24 Hour 100 MG, 200 MG, 300 MG, 360 MG</i>	T1	PA
<i>Verapamil HCl ER Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG</i>	T1	
<i>Verapamil HCl ER Oral Tablet Extended Release 120 MG, 180 MG, 240 MG</i>	T1	
<i>Verapamil HCl Oral</i>	T1	
Calcium-Channel Blocking Agents, Misc.		
<i>Diltiazem HCl Coated Beads (Cartia Xt Oral Capsule Extended Release 24 Hour 180 Mg, 240 Mg, 300 Mg)</i>	T1	
<i>Diltiazem HCl ER Beads Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG, 300 MG, 360 MG</i>	T1	
<i>Diltiazem HCl ER Beads Oral Capsule Extended Release 24 Hour 420 MG</i>	T1	PA
<i>dilTIAZem HCl ER Coated Beads Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG, 300 MG</i>	T1	
<i>dilTIAZem HCl ER Coated Beads Oral Capsule Extended Release 24 Hour 360 MG</i>	T1	PA
<i>dilTIAZem HCl ER Oral Capsule Extended Release 12 Hour</i>	T1	ST
<i>dilTIAZem HCl ER Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG</i>	T1	
<i>dilTIAZem HCl ER Oral Tablet Extended Release 24 Hour</i>	T1	PA
<i>dilTIAZem HCl Oral</i>	T1	
<i>Dilt-XR</i>	T1	
<i>Diltiazem HCl (Matzim La)</i>	T1	PA
<i>Diltiazem HCl ER Beads (Tiadylt Er Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg)</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Diltiazem HCl ER Beads</i> (Tiadylt Er Oral Capsule Extended Release 24 Hour 420 Mg)	T1	PA
<i>Verapamil HCl ER Oral Capsule Extended Release 24 Hour 100 MG, 200 MG, 300 MG, 360 MG</i>	T1	PA
<i>Verapamil HCl ER Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG</i>	T1	
<i>Verapamil HCl ER Oral Tablet Extended Release 120 MG, 180 MG, 240 MG</i>	T1	
<i>Verapamil HCl Oral</i>	T1	
Carbonic Anhydrase Inhibitors (24:36)		
<i>acetaZOLAMIDE ER</i>	T1	
<i>acetaZOLAMIDE Oral</i>	T1	
<i>methazolAMIDE Oral</i>	T1	PA
Carbonic Anhydrase Inhibitors(Hypoten)		
<i>acetaZOLAMIDE ER</i>	T1	
<i>acetaZOLAMIDE Oral</i>	T1	
<i>methazolAMIDE Oral</i>	T1	PA
Cardiotonic Agents		
<i>Digoxin</i> (Digox)	T1	
<i>Digoxin Oral Solution</i>	T1	
<i>Digoxin Oral Tablet 125 MCG, 250 MCG</i>	T1	
LANOXIN ORAL TABLET 125 MCG, 250 MCG (<i>Digoxin</i>)	T1	
Central Alpha-Agonists		
<i>Acebutolol HCl Oral</i>	T1	
<i>Atenolol Oral</i>	T1	
<i>Atenolol-Chlorthalidone</i>	T1	
<i>Betaxolol HCl Oral</i>	T1	PA
<i>Bisoprolol Fumarate Oral Tablet 10 MG, 5 MG</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Bisoprolol-hydroCHLOROthiazide</i>	T1	
<i>Carvedilol</i>	T1	
<i>cloNIDine</i>	T1	
<i>cloNIDine HCl Oral</i>	T1	
<i>guanFACINE HCl Oral</i>	T1	
INNOPRAN XL (<i>Propranolol HCl SR Beads</i>)	T1	
<i>Labetalol HCl Oral Tablet 100 MG, 200 MG, 300 MG</i>	T1	
<i>Methyldopa Oral</i>	T1	
<i>Metoprolol Succinate ER</i>	T1	
<i>Metoprolol Tartrate Oral Tablet 100 MG, 25 MG, 50 MG</i>	T1	
<i>Metoprolol-hydroCHLOROthiazide</i>	T1	PA
<i>Nadolol Oral Tablet 20 MG, 40 MG, 80 MG</i>	T1	
<i>Pindolol</i>	T1	PA
<i>Propranolol HCl ER</i>	T1	
<i>Propranolol HCl Oral</i>	T1	
<i>Sotalol HCl (AF)</i>	T1	
<i>Sotalol HCl Oral</i>	T1	
<i>Timolol Maleate Oral</i>	T1	PA
Cgmp Synthesis Agent		
VERQUVO (<i>Vericiguat</i>)	T1	PA
Cholesterol Absorption Inhibitors		
<i>Ezetimibe</i>	T1	
NEXLIZET (<i>Bempedoic Acid-Ezetimibe</i>)	T1	PA
Class Ia Antiarrhythmics		
<i>Disopyramide Phosphate Oral</i>	T1	
NORPACE CR (<i>Disopyramide Phosphate</i>)	T1	
<i>quiNIDine Gluconate ER</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>quinidine Sulfate Oral</i>	T1	
Class Ib Antiarrhythmics		
DILANTIN INFATABS (<i>Phenytoin</i>)	T1	
DILANTIN ORAL CAPSULE (<i>Phenytoin Sodium Extended</i>)	T1	
<i>Mexiletine HCl Oral</i>	T1	
<i>Phenytoin</i> (Phenytoin Infatabs)	T1	
<i>Phenytoin Oral</i>	T1	
<i>Phenytoin Sodium Extended</i>	T1	
Class Ic Antiarrhythmics		
<i>Flecainide Acetate</i>	T1	
<i>Propafenone HCl</i>	T1	
<i>Propafenone HCl ER</i>	T1	
Class Ii Antiarrhythmics		
<i>Acebutolol HCl Oral</i>	T1	
<i>Atenolol Oral</i>	T1	
<i>Atenolol-Chlorthalidone</i>	T1	
<i>Betaxolol HCl</i>	T1	PA
BETIMOL OPHTHALMIC SOLUTION 0.5 % (<i>Timolol Hemihydrate</i>)	T1	
BETOPTIC-S (<i>Betaxolol HCl</i>)	T1	PA
<i>Bisoprolol Fumarate Oral Tablet 10 MG, 5 MG</i>	T1	
<i>Bisoprolol-hydroCHLOROthiazide</i>	T1	
<i>Carvedilol</i>	T1	
INNOPRAN XL (<i>Propranolol HCl SR Beads</i>)	T1	
<i>Labetalol HCl Oral</i>	T1	
<i>Metoprolol Succinate ER</i>	T1	
<i>Metoprolol Tartrate Oral Tablet 100 MG, 25 MG, 50 MG</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Metoprolol-hydroCHLOROthiazide</i>	T1	PA
<i>Nadolol Oral Tablet 20 MG, 40 MG, 80 MG</i>	T1	
<i>Pindolol</i>	T1	PA
<i>Propranolol HCl ER</i>	T1	
<i>Propranolol HCl Oral</i>	T1	
<i>Sotalol HCl (AF)</i>	T1	
<i>Sotalol HCl Oral</i>	T1	
<i>Timolol Maleate (Once-Daily)</i>	T1	
<i>Timolol Maleate</i> (Timolol Maleate OcuDose)	T1	
<i>Timolol Maleate Ophthalmic</i>	T1	
<i>Timolol Maleate Oral</i>	T1	PA
<i>Timolol Maleate PF</i>	T1	
Class Iii Antiarrhythmics		
<i>Amiodarone HCl Oral</i>	T1	
<i>Dofetilide</i>	T1	
MULTAQ (<i>Dronedarone HCl</i>)	T1	PA
<i>Sotalol HCl (AF)</i>	T1	
<i>Sotalol HCl Oral</i>	T1	
Class Iv Antiarrhythmics		
<i>Diltiazem HCl Coated Beads</i> (Cartia Xt Oral Capsule Extended Release 24 Hour 180 Mg, 240 Mg, 300 Mg)	T1	
<i>Diltiazem HCl ER Beads Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG, 300 MG, 360 MG</i>	T1	
<i>Diltiazem HCl ER Beads Oral Capsule Extended Release 24 Hour 420 MG</i>	T1	PA
<i>dilTIAZem HCl ER Coated Beads Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG, 300 MG</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>diltiazem HCl ER Coated Beads Oral Capsule Extended Release 24 Hour 360 MG</i>	T1	PA
<i>diltiazem HCl ER Oral Capsule Extended Release 12 Hour</i>	T1	ST
<i>diltiazem HCl ER Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG</i>	T1	
<i>diltiazem HCl ER Oral Tablet Extended Release 24 Hour</i>	T1	PA
<i>diltiazem HCl Oral</i>	T1	
<i>Dilt-XR</i>	T1	
<i>Diltiazem HCl (Matzim La)</i>	T1	PA
<i>Diltiazem HCl ER Beads (Tiadyt Er Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg)</i>	T1	
<i>Diltiazem HCl ER Beads (Tiadyt Er Oral Capsule Extended Release 24 Hour 420 Mg)</i>	T1	PA
<i>Verapamil HCl ER Oral Capsule Extended Release 24 Hour 100 MG, 200 MG, 300 MG, 360 MG</i>	T1	PA
<i>Verapamil HCl ER Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG</i>	T1	
<i>Verapamil HCl ER Oral Tablet Extended Release 120 MG, 180 MG, 240 MG</i>	T1	
<i>Verapamil HCl Oral</i>	T1	
Dihydropyridines		
<i>amlodipine Besy-Benazepril HCl</i>	T1	
<i>amlodipine Besylate Oral</i>	T1	
<i>Felodipine ER</i>	T1	
<i>Isradipine</i>	T1	ST
<i>nifedipine HCl Oral</i>	T1	PA
<i>Nifedipine ER</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>NIFEdipine ER Osmotic Release</i>	T1	
<i>NIFEdipine Oral</i>	T1	
<i>niMODipine Oral Capsule</i>	T1	PA
Dihydropyridines (Antihypertensive)		
<i>amLODIPine Besy-Benazepril HCl</i>	T1	
<i>amLODIPine Besylate Oral</i>	T1	
<i>Felodipine ER</i>	T1	
<i>Isradipine</i>	T1	ST
<i>niCARDipine HCl Oral</i>	T1	PA
<i>NIFEdipine ER</i>	T1	
<i>NIFEdipine ER Osmotic Release</i>	T1	
<i>NIFEdipine Oral</i>	T1	
<i>niMODipine Oral Capsule</i>	T1	PA
Direct Vasodilators		
<i>cloNIDine</i>	T1	
<i>cloNIDine HCl Oral</i>	T1	
<i>guanFACINE HCl ER</i>	T1	
<i>guanFACINE HCl Oral</i>	T1	
<i>hydrALAZINE HCl Oral</i>	T1	
<i>Methyldopa Oral</i>	T1	
<i>Minoxidil Oral</i>	T1	
Diuretics, Miscellaneous (Hypotensive)		
THEO-24 (<i>Theophylline</i>)	T1	
<i>Theophylline ER Oral Tablet Extended Release 12 Hour 300 MG, 450 MG</i>	T1	
<i>Theophylline ER Oral Tablet Extended Release 24 Hour</i>	T1	
<i>Theophylline Oral Elixir</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Fibric Acid Derivatives		
<i>Fenofibrate Micronized Oral Capsule 130 MG, 43 MG</i>	T1	PA
<i>Fenofibrate Micronized Oral Capsule 134 MG</i>	T1	
<i>Fenofibrate Micronized Oral Capsule 200 MG, 67 MG</i>	T1	QL (30 EA per 30 days)
<i>Fenofibrate Oral Capsule 134 MG</i>	T1	
<i>Fenofibrate Oral Capsule 200 MG, 67 MG</i>	T1	QL (30 EA per 30 days)
<i>Fenofibrate Oral Tablet 145 MG, 160 MG, 48 MG, 54 MG</i>	T1	
<i>Gemfibrozil Oral</i>	T1	
Hmg-Coa Reductase Inhibitors		
<i>Atorvastatin Calcium Oral</i>	T1	
<i>Fluvastatin Sodium</i>	T1	PA
<i>Fluvastatin Sodium ER</i>	T1	PA
<i>Lovastatin Oral</i>	T1	
<i>Pravastatin Sodium</i>	T1	QL (30 EA per 30 days)
<i>Rosuvastatin Calcium Oral</i>	T1	QL (30 EA per 30 days)
<i>Simvastatin Oral Tablet</i>	T1	
Loop Diuretics (24:36)		
<i>Bumetanide Oral</i>	T1	
<i>Ethacrynic Acid Oral</i>	T1	
<i>Furosemide Oral Solution 10 MG/ML, 8 MG/ML</i>	T1	
<i>Furosemide Oral Tablet</i>	T1	
<i>Torsemide Oral</i>	T1	
Loop Diuretics (Hypotensive Agents)		
<i>Bumetanide Oral</i>	T1	
<i>Ethacrynic Acid Oral</i>	T1	
<i>Furosemide Oral Solution 10 MG/ML, 8 MG/ML</i>	T1	
<i>Furosemide Oral Tablet</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Torsemide Oral</i>	T1	
Mineralocorticoid (Aldosterone) Antagnts		
<i>Eplerenone</i>	T1	PA
KERENDIA (<i>Finerenone</i>)	T1	PA
<i>Spironolactone Oral Tablet</i>	T1	
<i>Spironolactone-HCTZ</i>	T1	
Mineralocorticoid(Aldoster.)Antag(Hypot)		
<i>Eplerenone</i>	T1	PA
<i>Spironolactone Oral Tablet</i>	T1	
<i>Spironolactone-HCTZ</i>	T1	
Nitrates And Nitrites		
<i>Acebutolol HCl Oral</i>	T1	
<i>Atenolol Oral</i>	T1	
<i>Atenolol-Chlorthalidone</i>	T1	
<i>Betaxolol HCl Oral</i>	T1	PA
<i>Bisoprolol Fumarate Oral Tablet 10 MG, 5 MG</i>	T1	
<i>Bisoprolol-hydroCHLOROthiazide</i>	T1	
<i>Carvedilol</i>	T1	
INNOPRAN XL (<i>Propranolol HCl SR Beads</i>)	T1	
<i>Isosorbide Dinitrate Oral</i>	T1	
<i>Isosorbide Mononitrate</i>	T1	
<i>Isosorbide Mononitrate ER</i>	T1	
<i>Labetalol HCl Oral Tablet 100 MG, 200 MG, 300 MG</i>	T1	
<i>Metoprolol Succinate ER</i>	T1	
<i>Metoprolol Tartrate Oral Tablet 100 MG, 25 MG, 50 MG</i>	T1	
<i>Metoprolol-hydroCHLOROthiazide</i>	T1	PA
<i>Nadolol Oral Tablet 20 MG, 40 MG, 80 MG</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NITRO-BID (<i>Nitroglycerin</i>)	T1	
<i>Nitroglycerin Sublingual</i>	T1	
<i>Nitroglycerin Transdermal Patch 24 Hour</i>	T1	
<i>Nitroglycerin Translingual Solution</i>	T1	PA
NITRO-TIME (<i>Nitroglycerin</i>)	T1	
<i>Pindolol</i>	T1	PA
<i>Propranolol HCl ER</i>	T1	
<i>Propranolol HCl Oral</i>	T1	
<i>Sotalol HCl (AF)</i>	T1	
<i>Sotalol HCl Oral</i>	T1	
<i>Timolol Maleate Oral</i>	T1	PA
Omega-3-Mediated Antilipemics		
<i>Omega-3-acid Ethyl Esters</i>	T1	ST
Pcsk9 Inhibitors		
PRALUENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>Alirocumab</i>)	T1	PA
REPATHA (<i>Evolocumab</i>)	T1	PA
REPATHA SURECLICK (<i>Evolocumab</i>)	T1	PA
Phosphodiesterase Type 5 Inhibitors		
<i>Aspirin-Dipyridamole ER</i>	T1	
<i>Diltiazem HCl Coated Beads</i> (Cartia Xt Oral Capsule Extended Release 24 Hour 180 Mg, 240 Mg, 300 Mg)	T1	
<i>Cilostazol</i>	T1	
<i>Diltiazem HCl ER Beads Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG, 300 MG, 360 MG</i>	T1	
<i>Diltiazem HCl ER Beads Oral Capsule Extended Release 24 Hour 420 MG</i>	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>diltiazem HCl ER Coated Beads Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG, 300 MG</i>	T1	
<i>diltiazem HCl ER Coated Beads Oral Capsule Extended Release 24 Hour 360 MG</i>	T1	PA
<i>diltiazem HCl ER Oral Capsule Extended Release 12 Hour</i>	T1	ST
<i>diltiazem HCl ER Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG</i>	T1	
<i>diltiazem HCl Oral</i>	T1	
<i>Dilt-XR</i>	T1	
<i>Dipyridamole Oral</i>	T1	
<i>Diltiazem HCl (Matzim La)</i>	T1	PA
<i>Sildenafil Citrate Oral Tablet 20 MG</i>	T1	PA
<i>Tadalafil (PAH)</i>	T1	PA
<i>Diltiazem HCl ER Beads (Tiadyt Er Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg)</i>	T1	
<i>Diltiazem HCl ER Beads (Tiadyt Er Oral Capsule Extended Release 24 Hour 420 Mg)</i>	T1	PA
<i>Verapamil HCl ER Oral Capsule Extended Release 24 Hour 100 MG, 200 MG, 300 MG, 360 MG</i>	T1	PA
<i>Verapamil HCl ER Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG</i>	T1	
<i>Verapamil HCl ER Oral Tablet Extended Release 120 MG, 180 MG, 240 MG</i>	T1	
<i>Verapamil HCl Oral</i>	T1	
Potassium-Sparing Diuretics (24:36)		
<i>aMiloride HCl Oral</i>	T1	
<i>Eplerenone</i>	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Spironolactone Oral Tablet</i>	T1	
<i>Spironolactone-HCTZ</i>	T1	
<i>Triamterene Oral</i>	T1	PA
Potassium-Sparing Diuretics (Hypoten)		
<i>aMILoride HCl Oral</i>	T1	
<i>aMILoride-hydroCHLOROthiazide</i>	T1	
<i>Eplerenone</i>	T1	PA
<i>Spironolactone Oral Tablet</i>	T1	
<i>Spironolactone-HCTZ</i>	T1	
<i>Triamterene Oral</i>	T1	PA
<i>Triamterene-HCTZ Oral Capsule 37.5-25 MG</i>	T1	
<i>Triamterene-HCTZ Oral Tablet</i>	T1	
Renin-Angioten.-Aldost. Sys. Inhib, Misc		
ENTRESTO ORAL CAPSULE SPRINKLE (<i>Sacubitril-Valsartan</i>)	T1	QL (240 EA per 30 days)
<i>Sacubitril-Valsartan</i>	T1	QL (60 EA per 30 days)
Steroidal Mineralocorticoid Receptor Ant		
<i>Eplerenone</i>	T1	PA
<i>Spironolactone Oral Tablet</i>	T1	
<i>Spironolactone-HCTZ</i>	T1	
Thiazide Diuretics (24:36)		
DIURIL (<i>Chlorothiazide</i>)	T1	
<i>hydroCHLOROthiazide Oral</i>	T1	
Thiazide Diuretics(Hypotensive Agents)		
<i>aMILoride-hydroCHLOROthiazide</i>	T1	
<i>Benazepril-hydroCHLOROthiazide</i>	T1	
<i>Bisoprolol-hydroCHLOROthiazide</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Candesartan Cilexetil-HCTZ Oral Tablet 16-12.5 MG, 32-12.5 MG</i>	T1	PA
<i>Captopril-hydroCHLOROthiazide</i>	T1	PA
<i>DIURIL (Chlorothiazide)</i>	T1	
<i>Enalapril-Hydrochlorothiazide Oral Tablet 10-25 MG</i>	T1	
<i>Enalapril-Hydrochlorothiazide Oral Tablet 5-12.5 MG</i>	T1	PA
<i>Fosinopril Sodium-HCTZ hydroCHLOROthiazide Oral</i>	T1	PA
<i>hydroCHLOROthiazide Oral</i>	T1	
<i>Irbesartan-hydroCHLOROthiazide</i>	T1	
<i>Lisinopril-hydroCHLOROthiazide</i>	T1	
<i>Losartan Potassium-HCTZ</i>	T1	
<i>Metoprolol-hydroCHLOROthiazide</i>	T1	PA
<i>Olmesartan Medoxomil-HCTZ</i>	T1	
<i>Quinapril-hydroCHLOROthiazide</i>	T1	
<i>Spirolactone-HCTZ</i>	T1	
<i>Telmisartan-HCTZ</i>	T1	PA
<i>Triamterene-HCTZ Oral Capsule 37.5-25 MG</i>	T1	
<i>Triamterene-HCTZ Oral Tablet</i>	T1	
<i>Valsartan-hydroCHLOROthiazide</i>	T1	
Thiazide-Like Diuretics (24:36)		
<i>Chlorthalidone Oral Tablet 25 MG, 50 MG</i>	T1	
<i>Indapamide Oral</i>	T1	
<i>metOLazone</i>	T1	
<i>THALITONE (Chlorthalidone)</i>	T1	
Thiazide-Like Diuretics(Hypotensive Agt)		
<i>Atenolol-Chlorthalidone</i>	T1	
<i>Chlorthalidone Oral Tablet 25 MG, 50 MG</i>	T1	
<i>Indapamide Oral</i>	T1	

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bold italics = Generic drugs UPPERCASE = Brand name drugs	Drug Tier	Coverage Requirements and Limits
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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>metOLazone</i>	T1	
THALITONE (<i>Chlorthalidone</i>)	T1	
Vasodilating Agents, Misc (24:08)		
<i>Acebutolol HCl Oral</i>	T1	
<i>amLODIPine Besy-Benazepril HCl</i>	T1	
<i>amLODIPine Besylate Oral</i>	T1	
<i>Betaxolol HCl Oral</i>	T1	PA
<i>Carvedilol</i>	T1	
<i>Doxazosin Mesylate Oral</i>	T1	
<i>Felodipine ER</i>	T1	
INNOPRAN XL (<i>Propranolol HCl SR Beads</i>)	T1	
<i>Isradipine</i>	T1	ST
<i>niCARDipine HCl Oral</i>	T1	PA
<i>NIFEdipine ER</i>	T1	
<i>NIFEdipine ER Osmotic Release</i>	T1	
<i>NIFEdipine Oral</i>	T1	
<i>niMODipine Oral Capsule</i>	T1	PA
<i>Phenoxybenzamine HCl Oral</i>	T1	
<i>Pindolol</i>	T1	PA
<i>Propranolol HCl ER</i>	T1	
<i>Propranolol HCl Oral</i>	T1	
<i>Sotalol HCl (AF)</i>	T1	
<i>Sotalol HCl Oral</i>	T1	
<i>Terazosin HCl Oral</i>	T1	
<i>Timolol Maleate Oral</i>	T1	PA
VECAMYL (<i>Mecamylamine HCl</i>)	T1	PA
Vasodilating Agents, Miscellaneous		

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADEMPAS (<i>Riociguat</i>)	T1	PA
<i>Ambrisentan</i>	T1	PA
<i>amLODIPine Besy-Benazepril HCl</i>	T1	
<i>amLODIPine Besylate Oral</i>	T1	
<i>Aspirin-Dipyridamole ER</i>	T1	
<i>Bosentan Oral Tablet</i>	T1	PA
<i>Diltiazem HCl Coated Beads</i> (Cartia Xt Oral Capsule Extended Release 24 Hour 180 Mg, 240 Mg, 300 Mg)	T1	
<i>Diltiazem HCl ER Beads Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG, 300 MG, 360 MG</i>	T1	
<i>Diltiazem HCl ER Beads Oral Capsule Extended Release 24 Hour 420 MG</i>	T1	PA
<i>dilTIAZem HCl ER Coated Beads Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG, 300 MG</i>	T1	
<i>dilTIAZem HCl ER Coated Beads Oral Capsule Extended Release 24 Hour 360 MG</i>	T1	PA
<i>dilTIAZem HCl ER Oral Capsule Extended Release 12 Hour</i>	T1	ST
<i>dilTIAZem HCl ER Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG</i>	T1	
<i>dilTIAZem HCl ER Oral Tablet Extended Release 24 Hour</i>	T1	PA
<i>dilTIAZem HCl Oral</i>	T1	
<i>Dilt-XR</i>	T1	
<i>Dipyridamole Oral</i>	T1	
<i>Felodipine ER</i>	T1	
<i>Isradipine</i>	T1	ST
<i>Diltiazem HCl</i> (Matzim La)	T1	PA
<i>niCARDipine HCl Oral</i>	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>NIFEdipine ER</i>	T1	
<i>NIFEdipine ER Osmotic Release</i>	T1	
<i>NIFEdipine Oral</i>	T1	
<i>niMODipine Oral Capsule</i>	T1	PA
OPSUMIT (<i>Macitentan</i>)	T1	PA
ORENITRAM (<i>Treprostinil Diolamine</i>)	T1	PA
<i>Diltiazem HCl ER Beads</i> (Tiadylt Er Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg)	T1	
<i>Diltiazem HCl ER Beads</i> (Tiadylt Er Oral Capsule Extended Release 24 Hour 420 Mg)	T1	PA
TRACLEER ORAL TABLET SOLUBLE (<i>Bosentan</i>)	T1	PA
<i>Treprostinil</i>	T1	PA
TYVASO (<i>Treprostinil</i>)	T1	PA
TYVASO REFILL KIT (<i>Treprostinil</i>)	T1	PA
TYVASO STARTER KIT (<i>Treprostinil</i>)	T1	PA
UPTRAVI ORAL (<i>Selexipag</i>)	T1	PA
UPTRAVI TITRATION (<i>Selexipag</i>)	T1	PA
<i>Verapamil HCl ER Oral Capsule Extended Release 24 Hour 100 MG, 200 MG, 300 MG, 360 MG</i>	T1	PA
<i>Verapamil HCl ER Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG</i>	T1	
<i>Verapamil HCl ER Oral Tablet Extended Release 120 MG, 180 MG, 240 MG</i>	T1	
<i>Verapamil HCl Oral</i>	T1	
VERQUVO (<i>Vericiguat</i>)	T1	PA
Central Nervous System Agents		
Adamantanes (Cns)		
<i>Amantadine HCl Oral Capsule</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Amantadine HCl Oral Solution 50 MG/5ML</i>	T1	
<i>Amantadine HCl Oral Tablet</i>	T1	
Amphetamines		
<i>Amphetamine-Dextroamphet ER</i>	T1	QL (30 EA per 30 days); AL (Max 18 Years)
<i>Amphetamine-Dextroamphetamine</i>	T1	QL (60 EA per 30 days); AL (Max 18 Years)
<i>Dextroamphetamine Sulfate ER</i>	T1	QL (30 EA per 30 days); AL (Max 18 Years)
<i>Dextroamphetamine Sulfate Oral Tablet 10 MG, 5 MG</i>	T1	QL (60 EA per 30 days); AL (Max 18 Years)
<i>Lisdexamfetamine Dimesylate</i>	T1	PA
<i>Methamphetamine HCl</i>	T1	PA
Amyotrophic Lateral Sclerosis(Als) Agent		
<i>Riluzole</i>	T1	
Analgesics And Antipyretics, Misc.		
<i>Acetaminophen-Codeine Oral Solution</i>	T1	QL (5000 ML per 30 days)
<i>Acetaminophen-Codeine Oral Tablet</i>	T1	QL (400 EA per 30 days)
<i>Butalbital-APAP-Caffeine</i> (Bac (Butalbital-Acetamin-Caff))	T1	QL (360 EA per 30 days)
<i>Butalbital-Acetaminophen Oral Tablet 50-325 MG</i>	T1	PA
<i>Butalbital-APAP-Caff-Cod Oral Capsule 50-325-40-30 MG</i>	T1	PA
<i>Butalbital-APAP-Caffeine Oral Capsule 50-325-40 MG</i>	T1	QL (360 EA per 30 days)
<i>Butalbital-APAP-Caffeine Oral Tablet 50-325-40 MG</i>	T1	QL (360 EA per 30 days)
<i>Oxycodone-Acetaminophen</i> (Endocet Oral Tablet 10-325 Mg, 5-325 Mg, 7.5-325 Mg)	T1	QL (360 EA per 30 days)
<i>Oxycodone-Acetaminophen</i> (Endocet Oral Tablet 2.5-325 Mg)	T1	PA
<i>Gabapentin Oral Capsule</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Gabapentin Oral Solution 250 MG/5ML</i>	T1	
<i>Gabapentin Oral Tablet 600 MG, 800 MG</i>	T1	
<i>HYDROcodone-Acetaminophen Oral Solution 2.5-108 MG/5ML, 5-217 MG/10ML, 7.5-325 MG/15ML</i>	T1	QL (5400 ML per 30 days)
<i>HYDROcodone-Acetaminophen Oral Tablet 10-325 MG, 5-325 MG, 7.5-325 MG</i>	T1	QL (360 EA per 30 days)
<i>oxyCODONE-Acetaminophen Oral Solution 5-325 MG/5ML</i>	T1	
<i>oxyCODONE-Acetaminophen Oral Tablet 10-325 MG, 5-325 MG, 7.5-325 MG</i>	T1	QL (360 EA per 30 days)
<i>oxyCODONE-Acetaminophen Oral Tablet 2.5-325 MG</i>	T1	PA
<i>Pregabalin Oral Capsule</i>	T1	
<i>Pregabalin Oral Solution</i>	T1	ST
<i>PRIALT (Ziconotide Acetate)</i>	T1	
<i>traMADol-Acetaminophen</i>	T1	QL (240 EA per 30 days)
Anorexigenic Agents		
<i>CONTRAVE (Naltrexone-Bupropion HCl)</i>	T1	PA
Anorexigenic Agents And Stimulants, Misc		
<i>Butalbital-ASA-Caff-Codeine (Ascomp-Codeine)</i>	T1	PA
<i>Butalbital-APAP-Caff-Cod Oral Capsule 50-325-40-30 MG</i>	T1	PA
<i>Butalbital-APAP-Caffeine Oral Capsule 50-325-40 MG</i>	T1	QL (360 EA per 30 days)
<i>Butalbital-APAP-Caffeine Oral Tablet 50-325-40 MG</i>	T1	QL (360 EA per 30 days)
<i>Butalbital-ASA-Caff-Codeine</i>	T1	PA
<i>Dexmethylphenidate HCl</i>	T1	QL (60 EA per 30 days); AL (Max 18 Years)
<i>Methylphenidate HCl ER (LA) Oral Capsule Extended Release 24 Hour 20 MG, 30 MG, 40 MG</i>	T1	QL (30 EA per 30 days); AL (Max 18 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Methylphenidate HCl ER (OSM) Oral Tablet Extended Release 18 MG, 27 MG, 54 MG</i>	T1	QL (30 EA per 30 days); AL (Max 18 Years)
<i>Methylphenidate HCl ER (OSM) Oral Tablet Extended Release 36 MG</i>	T1	QL (60 EA per 30 days); AL (Max 18 Years)
<i>Methylphenidate HCl ER Oral Tablet Extended Release</i>	T1	QL (90 EA per 30 days); AL (Max 18 Years)
<i>Methylphenidate HCl Oral Solution 10 MG/5ML</i>	T1	QL (450 ML per 30 days); AL (Max 18 Years)
<i>Methylphenidate HCl Oral Solution 5 MG/5ML</i>	T1	QL (900 ML per 30 days); AL (Max 18 Years)
<i>Methylphenidate HCl Oral Tablet</i>	T1	QL (90 EA per 30 days); AL (Max 18 Years)
<i>Modafinil Oral</i>	T1	PA
Anorexigenic Agents, Miscellaneous		
<i>CONTRAVE (Naltrexone-Bupropion HCl)</i>	T1	PA
<i>VICTOZA SUBCUTANEOUS SOLUTION PEN-INJECTOR (Liraglutide)</i>	T1	ST; QL (9 ML per 28 days)
Anticholinergic Agents (Cns)		
<i>Benztropine Mesylate Oral</i>	T1	QL (120 EA per 30 days)
<i>diphenhydrAMINE HCl Oral Capsule 25 MG</i>	T1	
<i>diphenhydrAMINE HCl Oral Elixir</i>	T1	
<i>Orphenadrine Citrate Injection</i>	T1	
<i>Trihexyphenidyl HCl</i>	T1	
Anticonvulsants, Miscellaneous		
<i>acetaZOLAMIDE ER</i>	T1	
<i>acetaZOLAMIDE Oral</i>	T1	
<i>carBAMazepine ER</i>	T1	
<i>carBAMazepine Oral Suspension 100 MG/5ML</i>	T1	
<i>carBAMazepine Oral Tablet</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>carBAMazepine Oral Tablet Chewable</i>	T1	
CARBATROL (<i>CarBAMazepine</i>)	T1	
DEPAKOTE (<i>Divalproex Sodium</i>)	T1	
DEPAKOTE ER (<i>Divalproex Sodium</i>)	T1	
DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE (<i>Divalproex Sodium</i>)	T1	
<i>Divalproex Sodium ER Oral Tablet Extended Release 24 Hour</i>	T1	
<i>Divalproex Sodium Oral Capsule Delayed Release Sprinkle</i>	T1	
<i>Divalproex Sodium Oral Tablet Delayed Release</i>	T1	
EPIDIOLEX (<i>Cannabidiol</i>)	T1	PA
<i>Felbamate</i>	T1	PA
<i>Gabapentin Oral Capsule</i>	T1	
<i>Gabapentin Oral Solution 250 MG/5ML</i>	T1	
<i>Gabapentin Oral Tablet 600 MG, 800 MG</i>	T1	
<i>Lacosamide Oral Tablet</i>	T1	
<i>lamoTRlgine Oral Tablet</i>	T1	
<i>LamoTRlgine Oral Tablet Chewable</i>	T1	
<i>levETIRAcetam Oral Solution</i>	T1	
<i>levETIRAcetam Oral Tablet</i>	T1	
<i>Magnesium Chloride Injection</i>	T1	
<i>Magnesium Sulfate Injection Solution 50 %</i>	T1	
<i>OXcarbazepine</i>	T1	
<i>Pregabalin Oral Capsule</i>	T1	
<i>Pregabalin Oral Solution</i>	T1	ST
<i>Rufinamide Oral Tablet</i>	T1	PA
<i>LamoTRlgine</i> (Subvenite Oral Tablet)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TEGRETOL ORAL SUSPENSION (<i>CarBAMazepine</i>)	T1	
TEGRETOL ORAL TABLET (<i>CarBAMazepine</i>)	T1	
TEGRETOL-XR (<i>CarBAMazepine</i>)	T1	
<i>tiaGABine HCl</i>	T1	
<i>Topiramate Oral Capsule Sprinkle</i>	T1	
<i>Topiramate Oral Tablet</i>	T1	
<i>Valproic Acid Oral Capsule</i>	T1	
<i>Valproic Acid Oral Solution 250 MG/5ML</i>	T1	
<i>Zonisamide Oral</i>	T1	
Antidepressants, Miscellaneous		
<i>buPROPion HCl ER (Smoking Det)</i>	T1	QL (60 EA per 30 days)
<i>buPROPion HCl ER (SR)</i>	T1	
<i>buPROPion HCl ER (XL) Oral Tablet Extended Release 24 Hour 150 MG, 300 MG</i>	T1	
<i>buPROPion HCl Oral</i>	T1	
<i>Mirtazapine Oral Tablet</i>	T1	
<i>Mirtazapine Oral Tablet Dispersible 15 MG, 30 MG</i>	T1	
<i>Mirtazapine Oral Tablet Dispersible 45 MG</i>	T1	PA
Antimanic Agents		
<i>ARIPiprazole Oral Solution</i>	T1	
<i>ARIPiprazole Oral Tablet</i>	T1	
<i>Asenapine Maleate</i>	T1	PA
<i>carBAMazepine ER</i>	T1	
<i>carBAMazepine Oral Suspension 100 MG/5ML</i>	T1	
<i>carBAMazepine Oral Tablet</i>	T1	
<i>carBAMazepine Oral Tablet Chewable</i>	T1	
CARBATROL (<i>CarBAMazepine</i>)	T1	
DEPAKOTE (<i>Divalproex Sodium</i>)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DEPAKOTE ER (<i>Divalproex Sodium</i>)	T1	
DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE (<i>Divalproex Sodium</i>)	T1	
<i>Divalproex Sodium ER Oral Tablet Extended Release 24 Hour</i>	T1	
<i>Divalproex Sodium Oral Capsule Delayed Release Sprinkle</i>	T1	
<i>Divalproex Sodium Oral Tablet Delayed Release</i>	T1	
<i>lamoTRlgine Oral Tablet</i>	T1	
<i>LamoTRlgine Oral Tablet Chewable</i>	T1	
<i>Lithium Carbonate ER</i>	T1	
<i>Lithium Carbonate Oral</i>	T1	
LITHOBID (<i>Lithium Carbonate</i>)	T1	
<i>OLANZapine Oral Tablet</i>	T1	QL (30 EA per 30 days)
<i>QUETiapine Fumarate ER Oral Tablet Extended Release 24 Hour 150 MG, 200 MG</i>	T1	QL (30 EA per 30 days)
<i>QUETiapine Fumarate ER Oral Tablet Extended Release 24 Hour 300 MG, 400 MG, 50 MG</i>	T1	QL (60 EA per 30 days)
<i>QUETiapine Fumarate Oral Tablet 100 MG, 200 MG, 25 MG, 300 MG, 400 MG, 50 MG</i>	T1	
<i>risperiDONE Oral Solution</i>	T1	
<i>risperiDONE Oral Tablet</i>	T1	
<i>risperiDONE Oral Tablet Dispersible 0.25 MG</i>	T1	QL (60 EA per 30 days)
<i>RisperiDONE Oral Tablet Dispersible 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG</i>	T1	
<i>LamoTRlgine</i> (Subvenite Oral Tablet)	T1	
TEGRETOL ORAL SUSPENSION (<i>CarBAMazepine</i>)	T1	
TEGRETOL ORAL TABLET (<i>CarBAMazepine</i>)	T1	
TEGRETOL-XR (<i>CarBAMazepine</i>)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Valproic Acid Oral Capsule</i>	T1	
<i>Valproic Acid Oral Solution 250 MG/5ML</i>	T1	
<i>Ziprasidone HCl</i>	T1	
<i>Ziprasidone Mesylate</i>	T1	
Antimigraine Agents, Miscellaneous		
AIMOVIG (<i>Erenumab-aooe</i>)	T1	PA
AJOVY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>Fremanezumab-vfrm</i>)	T1	PA
<i>Butalbital-ASA-Caff-Codeine</i> (Ascomp-Codeine)	T1	PA
<i>Aspirin 81</i>	T1	
<i>Aspirin Adult Low Dose</i>	T1	
<i>Aspirin Adult Low Strength Oral Tablet Delayed Release</i>	T1	
<i>Aspirin Childrens</i>	T1	
<i>Aspirin EC Adult Low Dose</i>	T1	
<i>Aspirin EC Low Dose</i>	T1	
<i>Aspirin EC Low Strength</i>	T1	
<i>Aspirin Low Dose Oral Tablet Chewable</i>	T1	
<i>Aspirin Low Dose Oral Tablet Delayed Release</i>	T1	
<i>Aspirin Low Strength</i>	T1	
<i>Aspirin Oral Tablet Chewable</i>	T1	
<i>Aspirin Oral Tablet Delayed Release 81 MG</i>	T1	
<i>Aspirin Regimen</i>	T1	
BAYER ASPIRIN EC LOW DOSE (<i>Aspirin</i>)	T1	
BAYER LOW DOSE ORAL TABLET DELAYED RELEASE (<i>Aspirin</i>)	T1	
<i>Butalbital-APAP-Caff-Cod Oral Capsule 50-325-40-30 MG</i>	T1	PA
<i>Butalbital-APAP-Caffeine Oral Capsule 50-325-40 MG</i>	T1	QL (360 EA per 30 days)

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary Medication; QY = Quantity; DY = Days; DS = Days Supply; EA = Each; GM = Gram; FL = Fill; ML = Milliliter; MIN = Minimum; MAX = Maximum

bold italics = Generic drugs UPPERCASE = Brand name drugs	Drug Tier	Coverage Requirements and Limits
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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Butalbital-APAP-Caffeine Oral Tablet 50-325-40 MG</i>	T1	QL (360 EA per 30 days)
<i>Butalbital-ASA-Caff-Codeine</i>	T1	PA
<i>Butalbital-Aspirin-Caffeine Oral Capsule</i>	T1	
<i>Childrens Aspirin</i>	T1	
<i>CVS Aspirin Adult Low Dose</i>	T1	
<i>CVS Aspirin EC Oral Tablet Delayed Release 81 MG</i>	T1	
<i>CVS Aspirin Low Dose</i>	T1	
<i>CVS Aspirin Low Strength Oral Tablet Delayed Release</i>	T1	
<i>DEPAKOTE (Divalproex Sodium)</i>	T1	
<i>DEPAKOTE ER (Divalproex Sodium)</i>	T1	
<i>DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE (Divalproex Sodium)</i>	T1	
<i>Dihydroergotamine Mesylate Injection</i>	T1	PA
<i>Divalproex Sodium ER Oral Tablet Extended Release 24 Hour</i>	T1	
<i>Divalproex Sodium Oral Capsule Delayed Release Sprinkle</i>	T1	
<i>Divalproex Sodium Oral Tablet Delayed Release</i>	T1	
<i>EC-Naproxen Oral Tablet Delayed Release 500 MG</i>	T1	
<i>ECOTRIN LOW STRENGTH (Aspirin)</i>	T1	
<i>EQ Aspirin Adult Low Dose</i>	T1	
<i>EQ Aspirin Low Dose Oral Tablet Chewable</i>	T1	
<i>EQL Aspirin Low Dose</i>	T1	
<i>Ergotamine-Caffeine</i>	T1	
<i>GNP Adult Aspirin Low Strength Oral Tablet Chewable</i>	T1	
<i>GNP Aspirin Low Dose</i>	T1	
<i>GNP Aspirin Oral Tablet Delayed Release 81 MG</i>	T1	
<i>GoodSense Aspirin Low Dose</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>GoodSense Aspirin Oral Tablet Chewable</i>	T1	
<i>Ibuprofen Oral Suspension 100 MG/5ML</i>	T1	
<i>Ibuprofen Oral Tablet 400 MG, 600 MG, 800 MG</i>	T1	
INNOPRAN XL (<i>Propranolol HCl SR Beads</i>)	T1	
<i>Ketoprofen ER</i>	T1	
<i>Ketoprofen Oral Capsule 50 MG</i>	T1	PA
MEDIQUE ASPIRIN (<i>Aspirin</i>)	T1	
MIGERGOT (<i>Ergotamine-Caffeine</i>)	T1	
<i>MM Aspirin Oral Tablet Delayed Release</i>	T1	
<i>Naproxen Oral</i>	T1	
<i>Naproxen Sodium ER Oral Tablet Extended Release 24 Hour 375 MG, 500 MG</i>	T1	
<i>Naproxen Sodium Oral Tablet 275 MG, 550 MG</i>	T1	
<i>Propranolol HCl ER</i>	T1	
<i>Propranolol HCl Oral</i>	T1	
<i>QC Aspirin Low Dose</i>	T1	
<i>Timolol Maleate Oral</i>	T1	PA
<i>Topiramate Oral Capsule Sprinkle</i>	T1	
<i>Topiramate Oral Tablet</i>	T1	
<i>traMADol-Acetaminophen</i>	T1	QL (240 EA per 30 days)
<i>Valproic Acid Oral Capsule</i>	T1	
<i>Valproic Acid Oral Solution 250 MG/5ML</i>	T1	
Antipsychotics, Miscellaneous		
<i>Loxapine Succinate Oral</i>	T1	
<i>Pimozide</i>	T1	
Anxiolytics, Sedatives, And Hypnotics, Misc		
BELSOMRA (<i>Suvorexant</i>)	T1	PA
<i>busPIRone HCl Oral</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DAYVIGO (<i>Lemborexant</i>)	T1	PA
<i>diphenhydrAMINE HCl Oral Capsule 25 MG</i>	T1	
<i>diphenhydrAMINE HCl Oral Elixir</i>	T1	
<i>Eszopiclone</i>	T1	
<i>hydrOXYzine HCl Oral Syrup</i>	T1	
<i>hydrOXYzine HCl Oral Tablet</i>	T1	
<i>hydrOXYzine Pamoate Oral</i>	T1	
<i>Meprobamate</i>	T1	PA
<i>Promethazine HCl Oral Solution 6.25 MG/5ML</i>	T1	
<i>Promethazine HCl Oral Tablet</i>	T1	
<i>Promethazine HCl Rectal Suppository 12.5 MG, 25 MG</i>	T1	
PROMETHEGAN (<i>Promethazine HCl</i>)	T1	
<i>Zaleplon Oral Capsule 10 MG</i>	T1	QL (60 EA per 30 days)
<i>Zaleplon Oral Capsule 5 MG</i>	T1	QL (30 EA per 30 days)
<i>Zolpidem Tartrate ER</i>	T1	QL (30 EA per 30 days)
<i>Zolpidem Tartrate Oral Tablet</i>	T1	QL (30 EA per 30 days)
Atypical Antipsychotics		
<i>ARIPiprazole Oral Solution</i>	T1	
<i>ARIPiprazole Oral Tablet</i>	T1	
<i>Asenapine Maleate</i>	T1	PA
<i>cloZAPine Oral Tablet</i>	T1	
<i>cloZAPine Oral Tablet Dispersible 100 MG, 25 MG</i>	T1	
<i>Lurasidone HCl</i>	T1	PA
<i>OLANZapine Oral Tablet</i>	T1	QL (30 EA per 30 days)
<i>QUETiapine Fumarate ER Oral Tablet Extended Release 24 Hour 150 MG, 200 MG</i>	T1	QL (30 EA per 30 days)
<i>QUETiapine Fumarate ER Oral Tablet Extended Release 24 Hour 300 MG, 400 MG, 50 MG</i>	T1	QL (60 EA per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
QUEtiapine Fumarate Oral Tablet 100 MG, 200 MG, 25 MG, 300 MG, 400 MG, 50 MG	T1	
risperiDONE Oral Solution	T1	
risperiDONE Oral Tablet	T1	
risperiDONE Oral Tablet Dispersible 0.25 MG	T1	QL (60 EA per 30 days)
RisperiDONE Oral Tablet Dispersible 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG	T1	
Ziprasidone HCl	T1	
Ziprasidone Mesylate	T1	
Barbiturates (Anticonvulsants)		
PB-Hyoscy-Atropine-Scopolamine	T1	
PHENobarbital Oral Elixir	T1	
PHENobarbital Oral Tablet	T1	
PHENobarbital-Belladonna Alk Oral Elixir	T1	
PHENOHYTRO ORAL TABLET (PB-Hyoscy-Atropine-Scopolamine)	T1	
Primidone Oral Tablet 250 MG, 50 MG	T1	
Barbiturates (Anxiolytic, Sedative/Hyp)		
Butalbital-ASA-Caff-Codeine (Ascomp-Codeine)	T1	PA
Butalbital-APAP-Caffeine (Bac (Butalbital-Acetamin-Caff))	T1	QL (360 EA per 30 days)
Butalbital-Acetaminophen Oral Tablet 50-325 MG	T1	PA
Butalbital-APAP-Caff-Cod Oral Capsule 50-325-40-30 MG	T1	PA
Butalbital-APAP-Caffeine Oral Capsule 50-325-40 MG	T1	QL (360 EA per 30 days)
Butalbital-APAP-Caffeine Oral Tablet 50-325-40 MG	T1	QL (360 EA per 30 days)
Butalbital-ASA-Caff-Codeine	T1	PA
Butalbital-Aspirin-Caffeine Oral Capsule	T1	
PB-Hyoscy-Atropine-Scopolamine	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>PHENobarbital Oral Elixir</i>	T1	
<i>PHENobarbital Oral Tablet</i>	T1	
<i>PHENobarbital-Belladonna Alk Oral Elixir</i>	T1	
PHENOHYTRO ORAL TABLET (<i>PB-Hyoscy-Atropine-Scopolamine</i>)	T1	
Benzodiazepines (Anticonvulsants)		
<i>cloBAZam Oral Tablet</i>	T1	QL (60 EA per 30 days)
<i>clonazePAM Oral</i>	T1	
<i>Clorazepate Dipotassium</i>	T1	
<i>Diazepam</i> (Diazepam Intensol)	T1	
<i>diazePAM Oral Concentrate</i>	T1	
<i>diazePAM Oral Solution 5 MG/5ML</i>	T1	
<i>diazePAM Oral Tablet</i>	T1	
<i>LORazepam</i> (Lorazepam Intensol)	T1	
<i>LORazepam Oral Concentrate 2 MG/ML</i>	T1	
<i>LORazepam Oral Tablet</i>	T1	
Benzodiazepines (Anxiolytic, Sedativ/Hyp)		
<i>ALPRAZolam ER</i>	T1	
ALPRAZOLAM INTENSOL (<i>ALPRAZolam</i>)	T1	
<i>ALPRAZolam Oral Tablet</i>	T1	
<i>ALPRAZolam Oral Tablet Dispersible</i>	T1	PA
<i>ALPRAZolam XR</i>	T1	
<i>chlordiazePOXIDE HCl</i>	T1	
<i>Chlordiazepoxide-Amitriptyline</i>	T1	
<i>chlordiazePOXIDE-Clidinium</i>	T1	
<i>cloBAZam Oral Tablet</i>	T1	QL (60 EA per 30 days)
<i>clonazePAM Oral</i>	T1	
<i>Clorazepate Dipotassium</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Diazepam</i> (Diazepam Intensol)	T1	
<i>diazePAM Oral Concentrate</i>	T1	
<i>diazePAM Oral Solution 5 MG/5ML</i>	T1	
<i>diazePAM Oral Tablet</i>	T1	
<i>Estazolam</i>	T1	
<i>LORazepam</i> (Lorazepam Intensol)	T1	
<i>LORazepam Oral Concentrate 2 MG/ML</i>	T1	
<i>LORazepam Oral Tablet</i>	T1	
<i>Oxazepam</i>	T1	PA
<i>Temazepam Oral Capsule 15 MG, 30 MG</i>	T1	
<i>Temazepam Oral Capsule 22.5 MG, 7.5 MG</i>	T1	PA
<i>Triazolam</i>	T1	
Butyrophenones		
<i>Haloperidol Decanoate Intramuscular Solution 100 MG/ML, 50 MG/ML</i>	T1	
<i>Haloperidol Lactate Oral Concentrate 2 MG/ML</i>	T1	
<i>Haloperidol Oral</i>	T1	
Calcitonin Gene-Related Peptide Antag.		
<i>AIMOVIG (Erenumab-aooe)</i>	T1	PA
<i>AJOVY (Fremanezumab-vfrm)</i>	T1	PA
<i>NURTEC (Rimegepant Sulfate)</i>	T1	PA
<i>UBRELVY (Ubrogepant)</i>	T1	PA
Catechol-O-Methyltransferase(Comt)Inhib.		
<i>Entacapone</i>	T1	
<i>Tolcapone</i>	T1	
Central Nervous System Agents, Misc.		
<i>Acamprosate Calcium</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Atomoxetine HCl Oral Capsule 10 MG, 18 MG, 25 MG, 40 MG, 60 MG</i>	T1	
<i>Atomoxetine HCl Oral Capsule 100 MG, 80 MG</i>	T1	AL (Max 18 Years)
<i>AUSTEDO (Deutetrabenazine)</i>	T1	PA
<i>Carbidopa Oral</i>	T1	
<i>guanFACINE HCl ER</i>	T1	
<i>guanFACINE HCl Oral</i>	T1	
<i>INGREZZA ORAL CAPSULE 40 MG, 80 MG (Valbenazine Tosylate)</i>	T1	PA
<i>Memantine HCl Oral Tablet</i>	T1	
<i>QELBREE (Viloxazine HCl)</i>	T1	PA
<i>Riluzole</i>	T1	
<i>Tetrabenazine</i>	T1	PA
Cyclooxygenase-2 (Cox-2) Inhibitors		
<i>Celecoxib Oral Capsule 100 MG, 200 MG</i>	T1	
<i>Celecoxib Oral Capsule 400 MG, 50 MG</i>	T1	PA
Dibenzoxapines		
<i>Loxapine Succinate Oral</i>	T1	
Diphenylbutylperidines		
<i>Pimozide</i>	T1	
Dopamine Precursors		
<i>Carbidopa Oral</i>	T1	
<i>Carbidopa-Levodopa</i>	T1	
<i>Carbidopa-Levodopa ER Oral Tablet Extended Release 25-100 MG, 50-200 MG</i>	T1	
<i>VYALEV SUBCUTANEOUS SOLUTION 12-240 MG/ML (Foscarbidopa-Foslevodopa)</i>	T1	PA
Ergot-Deriv. Dopamine Receptor Agonists		

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Bromocriptine Mesylate Oral</i>	T1	
<i>Cabergoline</i>	T1	
Fibromyalgia Agents		
<i>DULoxetine HCl Oral Capsule Delayed Release Particles 20 MG, 30 MG, 60 MG</i>	T1	QL (60 EA per 30 days)
<i>DULoxetine HCl Oral Capsule Delayed Release Particles 40 MG</i>	T1	PA
<i>Pregabalin Oral Capsule</i>	T1	
<i>Pregabalin Oral Solution</i>	T1	ST
SAVELLA (<i>Milnacipran HCl</i>)	T1	QL (60 EA per 30 days)
Gaba-Mediated Anticonvulsants		
DEPAKOTE (<i>Divalproex Sodium</i>)	T1	
DEPAKOTE ER (<i>Divalproex Sodium</i>)	T1	
<i>Divalproex Sodium ER Oral Tablet Extended Release 24 Hour</i>	T1	
<i>Divalproex Sodium Oral Tablet Delayed Release</i>	T1	
<i>Gabapentin Oral Capsule</i>	T1	
<i>Gabapentin Oral Solution 250 MG/5ML</i>	T1	
<i>Gabapentin Oral Tablet 600 MG, 800 MG</i>	T1	
<i>Pregabalin Oral Capsule</i>	T1	
<i>Pregabalin Oral Solution</i>	T1	ST
<i>tiaGABine HCl</i>	T1	
<i>Valproic Acid Oral Solution 250 MG/5ML</i>	T1	
Hydantoins		
DILANTIN INFATABS (<i>Phenytoin</i>)	T1	
DILANTIN ORAL CAPSULE (<i>Phenytoin Sodium Extended</i>)	T1	
<i>Phenytoin</i> (Phenytoin Infatabs)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Phenytoin Oral</i>	T1	
<i>Phenytoin Sodium Extended</i>	T1	
Ion Channel Inhibition Agents		
<i>Lacosamide Oral Tablet</i>	T1	
<i>OXcarbazepine</i>	T1	
<i>Rufinamide Oral Tablet</i>	T1	PA
<i>Zonisamide Oral</i>	T1	
Monoamine Oxidase B Inhibitors		
<i>Rasagiline Mesylate Oral</i>	T1	PA
<i>Selegiline HCl Oral</i>	T1	
Monoamine Oxidase Inhibitors		
<i>Phenelzine Sulfate Oral</i>	T1	PA
<i>Rasagiline Mesylate Oral</i>	T1	PA
<i>Selegiline HCl Oral</i>	T1	
<i>Tranylcypromine Sulfate</i>	T1	PA
Non-Benzodiazepine Anxiolytics		
<i>busPIRone HCl Oral</i>	T1	
<i>Meprobamate</i>	T1	PA
Non-Benzodiazepine Hypnotics		
<i>Eszopiclone</i>	T1	
<i>Zaleplon Oral Capsule 10 MG</i>	T1	QL (60 EA per 30 days)
<i>Zaleplon Oral Capsule 5 MG</i>	T1	QL (30 EA per 30 days)
<i>Zolpidem Tartrate ER</i>	T1	QL (30 EA per 30 days)
<i>Zolpidem Tartrate Oral Tablet</i>	T1	QL (30 EA per 30 days)
Nonergot-Deriv.Dopamine Receptor Agonist		
<i>Pramipexole Dihydrochloride</i>	T1	
<i>rOPINIRole HCl</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Non-Opioid Analgesics		
<i>Acetaminophen-Codeine Oral Solution</i>	T1	QL (5000 ML per 30 days)
<i>Acetaminophen-Codeine Oral Tablet</i>	T1	QL (400 EA per 30 days)
<i>Butalbital-APAP-Caffeine</i> (Bac (Butalbital-Acetamin-Caff))	T1	QL (360 EA per 30 days)
<i>Butalbital-Acetaminophen Oral Tablet 50-325 MG</i>	T1	PA
<i>Butalbital-APAP-Caff-Cod Oral Capsule 50-325-40-30 MG</i>	T1	PA
<i>Butalbital-APAP-Caffeine Oral Capsule 50-325-40 MG</i>	T1	QL (360 EA per 30 days)
<i>Butalbital-APAP-Caffeine Oral Tablet 50-325-40 MG</i>	T1	QL (360 EA per 30 days)
<i>Oxycodone-Acetaminophen</i> (Endocet Oral Tablet 10-325 Mg, 5-325 Mg, 7.5-325 Mg)	T1	QL (360 EA per 30 days)
<i>Oxycodone-Acetaminophen</i> (Endocet Oral Tablet 2.5-325 Mg)	T1	PA
<i>HYDROcodone-Acetaminophen Oral Solution 2.5-108 MG/5ML, 5-217 MG/10ML, 7.5-325 MG/15ML</i>	T1	QL (5400 ML per 30 days)
<i>HYDROcodone-Acetaminophen Oral Tablet 10-325 MG, 5-325 MG, 7.5-325 MG</i>	T1	QL (360 EA per 30 days)
<i>oxyCODONE-Acetaminophen Oral Solution 5-325 MG/5ML</i>	T1	
<i>oxyCODONE-Acetaminophen Oral Tablet 10-325 MG, 5-325 MG, 7.5-325 MG</i>	T1	QL (360 EA per 30 days)
<i>oxyCODONE-Acetaminophen Oral Tablet 2.5-325 MG</i>	T1	PA
<i>PRIALT (Ziconotide Acetate)</i>	T1	
<i>traMADol-Acetaminophen</i>	T1	QL (240 EA per 30 days)
Nonsteroidal Anti-Inflamm. Agents, Misc		
<i>Diclofenac Epolamine External</i>	T1	PA
<i>Diclofenac Potassium Oral Tablet 50 MG</i>	T1	
<i>Diclofenac Sodium ER</i>	T1	
<i>Diclofenac Sodium External Gel 1 %</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Diclofenac Sodium Oral</i>	T1	
<i>Diflunisal Oral</i>	T1	
<i>EC-Naproxen Oral Tablet Delayed Release 500 MG</i>	T1	
<i>Etodolac ER</i>	T1	
<i>Etodolac Oral</i>	T1	
<i>Flurbiprofen Oral Tablet 100 MG</i>	T1	PA
<i>HYDROcodone-Ibuprofen Oral Tablet 5-200 MG, 7.5-200 MG</i>	T1	
<i>Ibuprofen Oral Suspension 100 MG/5ML</i>	T1	
<i>Ibuprofen Oral Tablet 400 MG, 600 MG, 800 MG</i>	T1	
<i>Indomethacin ER</i>	T1	
<i>Indomethacin Oral Capsule 25 MG, 50 MG</i>	T1	
<i>Indomethacin Oral Suspension</i>	T1	
<i>Ketoprofen ER</i>	T1	
<i>Ketoprofen Oral Capsule 50 MG</i>	T1	PA
<i>Ketorolac Tromethamine Intramuscular Solution 60 MG/2ML</i>	T1	
<i>Ketorolac Tromethamine Oral</i>	T1	PA
<i>Meclofenamate Sodium Oral</i>	T1	PA
<i>Mefenamic Acid Oral</i>	T1	PA
<i>Meloxicam Oral Tablet</i>	T1	
<i>Nabumetone Oral</i>	T1	
<i>Naproxen Oral</i>	T1	
<i>Naproxen Sodium ER Oral Tablet Extended Release 24 Hour 375 MG, 500 MG</i>	T1	
<i>Naproxen Sodium Oral Tablet 275 MG, 550 MG</i>	T1	
<i>Oxaprozin Oral Tablet</i>	T1	QL (90 EA per 30 days)
<i>Piroxicam Oral</i>	T1	

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bold italics = Generic drugs UPPERCASE = Brand name drugs	Drug Tier	Coverage Requirements and Limits
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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Sulindac Oral</i>	T1	
Opioid Agonists (28:08)		
<i>Acetaminophen-Codeine Oral Solution</i>	T1	QL (5000 ML per 30 days)
<i>Acetaminophen-Codeine Oral Tablet</i>	T1	QL (400 EA per 30 days)
<i>Butalbital-ASA-Caff-Codeine</i> (Ascomp-Codeine)	T1	PA
<i>Butalbital-APAP-Caff-Cod Oral Capsule 50-325-40-30 MG</i>	T1	PA
<i>Butalbital-ASA-Caff-Codeine</i>	T1	PA
<i>Codeine Sulfate Oral Tablet</i>	T1	
<i>DISKETS (Methadone HCl)</i>	T1	
<i>Oxycodone-Acetaminophen</i> (Endocet Oral Tablet 10-325 Mg, 5-325 Mg, 7.5-325 Mg)	T1	QL (360 EA per 30 days)
<i>Oxycodone-Acetaminophen</i> (Endocet Oral Tablet 2.5-325 Mg)	T1	PA
<i>Fentanyl Cit-Ropivacaine-NaCl Epidural Solution 0.2-0.2-0.9 MG/100ML-%, 0.5-0.2-0.9 MG/250ML-%</i>	T1	
<i>fentaNYL Transdermal Patch 72 Hour 100 MCG/HR, 25 MCG/HR, 50 MCG/HR, 75 MCG/HR</i>	T1	PA
<i>Fentanyl-Bupivacaine-NaCl Epidural Solution 0.2-0.1-0.9 MG/100ML-%, 0.2-0.125-0.9 MG/100ML-%, 0.5-0.1-0.9 MG/250ML-%, 0.5-0.125-0.9 MG/250ML-%</i>	T1	
<i>HYDROcodone-Acetaminophen Oral Solution 2.5-108 MG/5ML, 5-217 MG/10ML, 7.5-325 MG/15ML</i>	T1	QL (5400 ML per 30 days)
<i>HYDROcodone-Acetaminophen Oral Tablet 10-325 MG, 5-325 MG, 7.5-325 MG</i>	T1	QL (360 EA per 30 days)
<i>HYDROcodone-Ibuprofen Oral Tablet 5-200 MG, 7.5-200 MG</i>	T1	
<i>HYDROmorphine HCl Oral</i>	T1	
<i>HYDROmorphine HCl Rectal</i>	T1	
<i>Levorphanol Tartrate Oral Tablet 2 MG</i>	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Meperidine HCl Oral Solution</i>	T1	PA
<i>Meperidine HCl Oral Tablet 50 MG</i>	T1	PA
<i>Methadone HCl</i> (Methadone Hcl Intensol)	T1	
<i>Methadone HCl Oral</i>	T1	
<i>Morphine Sulfate (Concentrate) Oral Solution 10 MG/0.5ML, 100 MG/5ML, 20 MG/ML</i>	T1	
<i>Morphine Sulfate ER Beads Oral Capsule Extended Release 24 Hour 120 MG, 30 MG, 60 MG, 90 MG</i>	T1	PA
<i>Morphine Sulfate ER Oral Capsule Extended Release 24 Hour 10 MG, 100 MG, 20 MG, 30 MG, 50 MG, 60 MG, 80 MG</i>	T1	PA
<i>Morphine Sulfate ER Oral Tablet Extended Release 15 MG, 30 MG, 60 MG</i>	T1	
<i>Morphine Sulfate Oral</i>	T1	
<i>Morphine Sulfate Rectal</i>	T1	
NUCYNTA (<i>Tapentadol HCl</i>)	T1	PA
NUCYNTA ER (<i>Tapentadol HCl</i>)	T1	PA
<i>Opium</i>	T1	PA
<i>oxyCODONE HCl Oral Concentrate 100 MG/5ML</i>	T1	PA
<i>oxyCODONE HCl Oral Solution</i>	T1	PA
<i>oxyCODONE HCl Oral Tablet 15 MG, 20 MG, 30 MG</i>	T1	PA
<i>oxyCODONE HCl Oral Tablet 5 MG</i>	T1	QL (10 EA per 1 day)
<i>oxyCODONE HCl Oral Tablet Abuse-Deterrent 15 MG, 5 MG</i>	T1	PA
<i>oxyCODONE-Acetaminophen Oral Solution 5-325 MG/5ML</i>	T1	
<i>oxyCODONE-Acetaminophen Oral Tablet 10-325 MG, 5-325 MG, 7.5-325 MG</i>	T1	QL (360 EA per 30 days)
<i>oxyCODONE-Acetaminophen Oral Tablet 2.5-325 MG</i>	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Promethazine-Codeine</i>	T1	QL (240 ML per 30 days); AL (Min 18 Years)
<i>traMADol HCl Oral Tablet 50 MG</i>	T1	
<i>traMADol-Acetaminophen</i>	T1	QL (240 EA per 30 days)
Opioid Antagonists (28:10)		
<i>Buprenorphine HCl-Naloxone HCl</i>	T1	
<i>GNP Naloxone HCl</i>	T1	
KLOXXADO (<i>Naloxone HCl</i>)	T1	QL (4 EA per 180 days)
<i>Naloxone HCl Injection Solution 0.4 MG/ML, 4 MG/10ML</i>	T1	
<i>Naloxone HCl Injection Solution Cartridge</i>	T1	
<i>Naloxone HCl Injection Solution Prefilled Syringe 2 MG/2ML</i>	T1	
<i>Naloxone HCl Nasal</i>	T1	
<i>Naltrexone HCl Oral</i>	T1	
<i>Pentazocine-Naloxone HCl</i>	T1	PA
RELISTOR ORAL (<i>Methylnaltrexone Bromide</i>)	T1	PA
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML (<i>Methylnaltrexone Bromide</i>)	T1	PA
RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>Methylnaltrexone Bromide</i>)	T1	PA
REXTOVY (<i>Naloxone HCl</i>)	T1	QL (4 EA per 180 days)
RIVIVE (<i>Naloxone HCl</i>)	T1	QL (4 EA per 180 days)
VIVITROL (<i>Naltrexone</i>)	T1	
Opioid Partial Agonists		
<i>Buprenorphine HCl Sublingual</i>	T1	
<i>Buprenorphine HCl-Naloxone HCl</i>	T1	
<i>Pentazocine-Naloxone HCl</i>	T1	PA
SUBLOCADE (<i>Buprenorphine</i>)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Orexin Receptor Antagonists		
BELSOMRA (<i>Suvorexant</i>)	T1	PA
DAYVIGO (<i>Lemborexant</i>)	T1	PA
QUVIVIQ (<i>Daridorexant HCl</i>)	T1	PA
Phenothiazines		
<i>chlorproMAZINE HCl Oral Concentrate 100 MG/ML</i>	T1	
<i>chlorproMAZINE HCl Oral Tablet</i>	T1	
<i>Prochlorperazine</i> (Compro)	T1	
<i>fluPHENAZine HCl Oral</i>	T1	
<i>Perphenazine Oral</i>	T1	
<i>Perphenazine-Amitriptyline</i>	T1	
<i>Prochlorperazine</i>	T1	
<i>Prochlorperazine Maleate Oral</i>	T1	
<i>Thioridazine HCl Oral</i>	T1	
<i>Trifluoperazine HCl Oral</i>	T1	
Respiratory And Cns Stimulants		
<i>Butalbital-ASA-Caff-Codeine</i> (Ascomp-Codeine)	T1	PA
<i>Atomoxetine HCl Oral Capsule 10 MG, 18 MG, 25 MG, 40 MG, 60 MG</i>	T1	
<i>Atomoxetine HCl Oral Capsule 100 MG, 80 MG</i>	T1	AL (Max 18 Years)
<i>Butalbital-APAP-Caffeine</i> (Bac (Butalbital-Acetamin-Caff))	T1	QL (360 EA per 30 days)
<i>Butalbital-APAP-Caff-Cod Oral Capsule 50-325-40-30 MG</i>	T1	PA
<i>Butalbital-APAP-Caffeine Oral Capsule 50-325-40 MG</i>	T1	QL (360 EA per 30 days)
<i>Butalbital-APAP-Caffeine Oral Tablet 50-325-40 MG</i>	T1	QL (360 EA per 30 days)
<i>Butalbital-ASA-Caff-Codeine</i>	T1	PA
<i>Butalbital-Aspirin-Caffeine Oral Capsule</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Dexmethylphenidate HCl</i>	T1	QL (60 EA per 30 days); AL (Max 18 Years)
<i>Dexmethylphenidate HCl ER Oral Capsule Extended Release 24 Hour 10 MG, 5 MG</i>	T1	QL (60 EA per 30 days); AL (Max 18 Years)
<i>Dexmethylphenidate HCl ER Oral Capsule Extended Release 24 Hour 15 MG, 20 MG</i>	T1	QL (30 EA per 30 days); AL (Max 18 Years)
<i>Ergotamine-Caffeine</i>	T1	
<i>Methylphenidate HCl ER (CD)</i>	T1	QL (30 EA per 30 days); AL (Max 18 Years)
<i>Methylphenidate HCl ER (LA)</i>	T1	QL (30 EA per 30 days); AL (Max 18 Years)
<i>Methylphenidate HCl ER (OSM) Oral Tablet Extended Release 18 MG, 27 MG, 54 MG, 72 MG</i>	T1	QL (30 EA per 30 days); AL (Max 18 Years)
<i>Methylphenidate HCl ER (OSM) Oral Tablet Extended Release 36 MG</i>	T1	QL (60 EA per 30 days); AL (Max 18 Years)
<i>Methylphenidate HCl ER Oral Tablet Extended Release</i>	T1	QL (90 EA per 30 days); AL (Max 18 Years)
<i>Methylphenidate HCl ER Oral Tablet Extended Release 24 Hour 18 MG, 27 MG, 54 MG</i>	T1	QL (30 EA per 30 days); AL (Max 18 Years)
<i>Methylphenidate HCl ER Oral Tablet Extended Release 24 Hour 36 MG</i>	T1	QL (60 EA per 30 days); AL (Max 18 Years)
<i>Methylphenidate HCl Oral Solution 10 MG/5ML</i>	T1	QL (450 ML per 30 days); AL (Max 18 Years)
<i>Methylphenidate HCl Oral Solution 5 MG/5ML</i>	T1	QL (900 ML per 30 days); AL (Max 18 Years)
<i>Methylphenidate HCl Oral Tablet</i>	T1	QL (90 EA per 30 days); AL (Max 18 Years)
<i>Methylphenidate HCl Oral Tablet Chewable</i>	T1	QL (30 EA per 30 days); AL (Max 18 Years)
MIGERGOT (<i>Ergotamine-Caffeine</i>)	T1	
<i>Norgesic Forte</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Orphenadrine-Aspirin-Caffeine Oral Tablet 25-385-30 MG</i>	T1	
ORPHENGESIC FORTE ORAL TABLET 50-770-60 MG (<i>Orphenadrine-Aspirin-Caffeine</i>)	T1	
QELBREE (<i>Viloxazine HCl</i>)	T1	PA
THEO-24 (<i>Theophylline</i>)	T1	
<i>Theophylline ER Oral Tablet Extended Release 12 Hour 300 MG, 450 MG</i>	T1	
<i>Theophylline ER Oral Tablet Extended Release 24 Hour</i>	T1	
<i>Theophylline Oral Elixir</i>	T1	
Reversible Cox-1/Cox-2 Inhibitors		
<i>Diflunisal Oral</i>	T1	
<i>EC-Naproxen Oral Tablet Delayed Release 500 MG</i>	T1	
<i>Etodolac ER</i>	T1	
<i>Etodolac Oral</i>	T1	
<i>Flurbiprofen Oral Tablet 100 MG</i>	T1	PA
<i>Flurbiprofen Sodium</i>	T1	
<i>HYDROcodone-Ibuprofen Oral Tablet 5-200 MG, 7.5-200 MG</i>	T1	
<i>Ibuprofen Oral Suspension 100 MG/5ML</i>	T1	
<i>Ibuprofen Oral Tablet 400 MG, 600 MG, 800 MG</i>	T1	
<i>Indomethacin ER</i>	T1	
<i>Indomethacin Oral Capsule 25 MG, 50 MG</i>	T1	
<i>Indomethacin Oral Suspension</i>	T1	
<i>Ketorolac Tromethamine Intramuscular Solution 60 MG/2ML</i>	T1	
<i>Ketorolac Tromethamine Ophthalmic</i>	T1	
<i>Ketorolac Tromethamine Oral</i>	T1	PA
<i>Meclofenamate Sodium Oral</i>	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Mefenamic Acid Oral</i>	T1	PA
<i>Meloxicam Oral Tablet</i>	T1	
<i>Nabumetone Oral</i>	T1	
<i>Naproxen Oral</i>	T1	
<i>Naproxen Sodium ER Oral Tablet Extended Release 24 Hour 375 MG, 500 MG</i>	T1	
<i>Naproxen Sodium Oral Tablet 275 MG, 550 MG</i>	T1	
<i>Oxaprozin Oral Tablet</i>	T1	QL (90 EA per 30 days)
<i>Piroxicam Oral</i>	T1	
<i>Sulindac Oral</i>	T1	
Salicylates		
<i>Butalbital-ASA-Caff-Codeine (Ascomp-Codeine)</i>	T1	PA
<i>Aspirin 81</i>	T1	
<i>Aspirin Adult Low Dose</i>	T1	
<i>Aspirin Adult Low Strength Oral Tablet Delayed Release</i>	T1	
<i>Aspirin Childrens</i>	T1	
<i>Aspirin EC Adult Low Dose</i>	T1	
<i>Aspirin EC Low Dose</i>	T1	
<i>Aspirin EC Low Strength</i>	T1	
<i>Aspirin Low Dose Oral Tablet Chewable</i>	T1	
<i>Aspirin Low Dose Oral Tablet Delayed Release</i>	T1	
<i>Aspirin Low Strength</i>	T1	
<i>Aspirin Oral Tablet Chewable</i>	T1	
<i>Aspirin Oral Tablet Delayed Release 81 MG</i>	T1	
<i>Aspirin Regimen</i>	T1	
<i>Aspirin-Dipyridamole ER</i>	T1	
BAYER ASPIRIN EC LOW DOSE (<i>Aspirin</i>)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BAYER LOW DOSE ORAL TABLET DELAYED RELEASE (<i>Aspirin</i>)	T1	
<i>Butalbital-ASA-Caff-Codeine</i>	T1	PA
<i>Butalbital-Aspirin-Caffeine Oral Capsule</i>	T1	
<i>Childrens Aspirin</i>	T1	
<i>CVS Aspirin Adult Low Dose</i>	T1	
<i>CVS Aspirin EC Oral Tablet Delayed Release 81 MG</i>	T1	
<i>CVS Aspirin Low Dose</i>	T1	
<i>CVS Aspirin Low Strength Oral Tablet Delayed Release</i>	T1	
ECOTRIN LOW STRENGTH (<i>Aspirin</i>)	T1	
<i>EQ Aspirin Adult Low Dose</i>	T1	
<i>EQ Aspirin Low Dose Oral Tablet Chewable</i>	T1	
<i>EQL Aspirin Low Dose</i>	T1	
<i>GNP Adult Aspirin Low Strength Oral Tablet Chewable</i>	T1	
<i>GNP Aspirin Low Dose</i>	T1	
<i>GNP Aspirin Oral Tablet Delayed Release 81 MG</i>	T1	
<i>GoodSense Aspirin Low Dose</i>	T1	
<i>GoodSense Aspirin Oral Tablet Chewable</i>	T1	
MEDIQUE ASPIRIN (<i>Aspirin</i>)	T1	
<i>MM Aspirin Oral Tablet Delayed Release</i>	T1	
<i>Norgesic Forte</i>	T1	
<i>Orphenadrine-Aspirin-Caffeine Oral Tablet 25-385-30 MG</i>	T1	
ORPHENGESIC FORTE ORAL TABLET 50-770-60 MG (<i>Orphenadrine-Aspirin-Caffeine</i>)	T1	
<i>QC Aspirin Low Dose</i>	T1	
<i>Salsalate Oral</i>	T1	
Sel.Serotonin,Norepi Reuptake Inhibitor		

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>DULoxetine HCl Oral Capsule Delayed Release Particles 20 MG, 30 MG, 60 MG</i>	T1	QL (60 EA per 30 days)
<i>DULoxetine HCl Oral Capsule Delayed Release Particles 40 MG</i>	T1	PA
<i>SAVELLA (Milnacipran HCl)</i>	T1	QL (60 EA per 30 days)
<i>Venlafaxine HCl</i>	T1	
<i>Venlafaxine HCl ER Oral Capsule Extended Release 24 Hour</i>	T1	
Selective Serotonin Agonists		
<i>Naratriptan HCl</i>	T1	ST; QL (12 EA per 30 days)
<i>Rizatriptan Benzoate</i>	T1	QL (12 EA per 30 days)
<i>SUMatriptan Succinate Oral Tablet 100 MG, 50 MG</i>	T1	QL (18 EA per 30 days)
<i>SUMatriptan Succinate Oral Tablet 25 MG</i>	T1	QL (12 EA per 30 days)
<i>SUMatriptan Succinate Subcutaneous Solution 6 MG/0.5ML</i>	T1	PA
Selective-Serotonin Reuptake Inhibitors		
<i>Citalopram Hydrobromide Oral Solution</i>	T1	QL (900 ML per 30 days)
<i>Citalopram Hydrobromide Oral Tablet 10 MG, 20 MG</i>	T1	QL (90 EA per 30 days)
<i>Citalopram Hydrobromide Oral Tablet 40 MG</i>	T1	QL (45 EA per 30 days)
<i>Escitalopram Oxalate Oral Solution 5 MG/5ML</i>	T1	
<i>Escitalopram Oxalate Oral Tablet</i>	T1	
<i>FLUoxetine HCl Oral Capsule</i>	T1	
<i>FLUoxetine HCl Oral Capsule Delayed Release</i>	T1	PA
<i>FLUoxetine HCl Oral Solution</i>	T1	
<i>fluvoxamine Maleate</i>	T1	
<i>PARoxetine HCl</i>	T1	
<i>PARoxetine HCl ER</i>	T1	PA
<i>Sertraline HCl Oral Concentrate</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Sertraline HCl Oral Tablet</i>	T1	
Serotonin Modulators		
<i>Mirtazapine Oral Tablet</i>	T1	
<i>Mirtazapine Oral Tablet Dispersible 15 MG, 30 MG</i>	T1	
<i>Mirtazapine Oral Tablet Dispersible 45 MG</i>	T1	PA
<i>Nefazodone HCl</i>	T1	
<i>traZODone HCl Oral</i>	T1	
TRINTELLIX (<i>Vortioxetine HBr</i>)	T1	PA
Succinimides		
<i>Ethosuximide Oral</i>	T1	
Thioxanthenes		
<i>Thiothixene Oral</i>	T1	
Tricyclics, Other Norepi-Ru Inhibitors		
<i>Amitriptyline HCl Oral</i>	T1	
<i>Amoxapine</i>	T1	
<i>Chlordiazepoxide-Amitriptyline</i>	T1	
<i>clomiPRAMINE HCl Oral</i>	T1	
<i>Desipramine HCl Oral</i>	T1	
<i>Doxepin HCl External</i>	T1	
<i>Doxepin HCl Oral Capsule</i>	T1	
<i>Doxepin HCl Oral Concentrate</i>	T1	
<i>Doxepin HCl Oral Tablet</i>	T1	PA
<i>Imipramine HCl Oral</i>	T1	
<i>Imipramine Pamoate</i>	T1	
<i>Nortriptyline HCl Oral</i>	T1	
<i>Perphenazine-Amitriptyline</i>	T1	
<i>Protriptyline HCl</i>	T1	PA

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	SCO = State Carve Out T1 = Preferred Medication T2 = Preferred Medication with Restriction T3 = Non-Preferred Medication - Prior Authorization is Required	AL = Age Limit PA = Prior Authorization QL = Quantity Limit SCO = State Carve Out ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Trimipramine Maleate Oral</i>	T1	
Vesicular Monoamine Transport2 Inhibitor		
AUSTEDO (<i>Deutetrabenazine</i>)	T1	PA
AUSTEDO XR (<i>Deutetrabenazine</i>)	T1	PA
AUSTEDO XR PATIENT TITRATION ORAL TABLET EXTENDED RELEASE THERAPY PACK 12 & 18 & 24 & 30 MG (<i>Deutetrabenazine</i>)	T1	PA
INGREZZA ORAL CAPSULE (<i>Valbenazine Tosylate</i>)	T1	PA
INGREZZA ORAL CAPSULE SPRINKLE (<i>Valbenazine Tosylate</i>)	T1	PA
<i>Tetrabenazine</i>	T1	PA
Wakefulness-Promoting Agents		
<i>Diclofenac Sodium Oral Tablet Delayed Release 75 MG</i>	T1	
<i>Modafinil Oral</i>	T1	PA
Dental Agents		
Dental Agents		
DENTA 5000 PLUS (<i>Sodium Fluoride</i>)	T1	
<i>Multivitamin/Fluoride Oral Tablet Chewable 0.25 MG, 0.5 MG, 1 MG</i>	T1	
PREVIDENT DENTAL (<i>Sodium Fluoride</i>)	T1	
<i>SF</i>	T1	
<i>SF 5000 Plus</i>	T1	
<i>Sodium Fluoride 5000 Plus</i>	T1	
<i>Sodium Fluoride Dental Cream</i>	T1	
<i>Sodium Fluoride Dental Gel 1.1 %</i>	T1	
<i>Sodium Fluoride Mouth/Throat</i>	T1	
<i>Sodium Fluoride Oral Solution 1.1 (0.5 F) MG/ML</i>	T1	
<i>Sodium Fluoride Oral Tablet Chewable</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Tri-Vite/Fluoride Oral Solution 0.25 MG/ML</i>	T1	
Nutritional Supplements		
DENTA 5000 PLUS (<i>Sodium Fluoride</i>)	T1	
<i>Multivitamin/Fluoride Oral Tablet Chewable 0.25 MG, 0.5 MG, 1 MG</i>	T1	
PREVIDENT DENTAL (<i>Sodium Fluoride</i>)	T1	
<i>SF</i>	T1	
<i>SF 5000 Plus</i>	T1	
<i>Sodium Fluoride 5000 Plus</i>	T1	
<i>Sodium Fluoride Dental Cream</i>	T1	
<i>Sodium Fluoride Dental Gel 1.1 %</i>	T1	
<i>Sodium Fluoride Mouth/Throat</i>	T1	
<i>Sodium Fluoride Oral Solution 1.1 (0.5 F) MG/ML</i>	T1	
<i>Sodium Fluoride Oral Tablet Chewable</i>	T1	
<i>Tri-Vite/Fluoride Oral Solution 0.25 MG/ML</i>	T1	
Devices		
Devices		
ACCU-CHEK SOFTCLIX LANCETS (<i>Lancets</i>)	T1	
ACE AEROSOL CLOUD ENHANCER (<i>Respiratory Therapy Supplies</i>)	T1	QL (2 EA per 365 days)
AEROCHAMBER PLUS FLO-VU LARGE (<i>Spacer/Aero-Holding Chambers</i>)	T1	QL (2 EA per 365 days)
AEROCHAMBER PLUS FLO-VU SMALL (<i>Spacer/Aero-Holding Chambers</i>)	T1	QL (2 EA per 365 days)
AQUALANCE LANCETS 30G (<i>Lancets</i>)	T1	
BD DISP NEEDLE 23G X 1" (<i>Needle (Disp)</i>)	T1	
BD DISP NEEDLES 18G X 1-1/2" , 25G X 5/8" (<i>Needle (Disp)</i>)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BD INSULIN SYRINGE 29G X 1/2" 1 ML (<i>Insulin Syringe-Needle U-100</i>)	T1	
BD INSULIN SYRINGE MICROFINE 28G X 1/2" 0.5 ML, 28G X 1/2" 1 ML (<i>Insulin Syringe-Needle U-100</i>)	T1	
BD INSULIN SYRINGE ULTRAFINE 30G X 1/2" 0.5 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML (<i>Insulin Syringe-Needle U-100</i>)	T1	
BD INTEGRA SYRINGE 21G X 1-1/2" 3 ML, 23G X 1" 3 ML, 25G X 5/8" 3 ML (<i>Syringe/Needle (Disp)</i>)	T1	
BD LUER-LOK SYRINGE 18G X 1-1/2" 3 ML, 20G X 1" 3 ML, 22G X 1" 3 ML, 23G X 1" 3 ML, 23G X 1-1/2" 3 ML, 25G X 1" 3 ML (<i>Syringe/Needle (Disp)</i>)	T1	
BD PEN NEEDLE MINI U/F (<i>Insulin Pen Needle</i>)	T1	
BD PEN NEEDLE MINI ULTRAFINE (<i>Insulin Pen Needle</i>)	T1	
BD PEN NEEDLE NANO 2ND GEN (<i>Insulin Pen Needle</i>)	T1	
BD PEN NEEDLE NANO ULTRAFINE (<i>Insulin Pen Needle</i>)	T1	
BD PEN NEEDLE ORIG ULTRAFINE (<i>Insulin Pen Needle</i>)	T1	
BD PEN NEEDLE SHORT ULTRAFINE (<i>Insulin Pen Needle</i>)	T1	
BD PLASTIPAK SYRINGE 21G X 1" 3 ML (<i>Syringe/Needle (Disp)</i>)	T1	
BD SYRINGE/NEEDLE 22G X 1-1/2" 3 ML (<i>Syringe/Needle (Disp)</i>)	T1	
BD TB SYRINGE 27G X 1/2" 1 ML (<i>Tuberculin-Allergy Syringes</i>)	T1	
BD VEO INSULIN SYR ULTRAFINE (<i>Insulin Syringe-Needle U-100</i>)	T1	
BINAXNOW COVID-19 AG HOME TEST (<i>COVID-19 At Home Test</i>)	T1	QL (8 EA per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COMFORT EZ PEN NEEDLES 32G X 4 MM (<i>Insulin Pen Needle</i>)	T1	
COMPACT SPACE CHAMBER (<i>Spacer/Aero-Holding Chambers</i>)	T1	QL (2 EA per 365 days)
DROPLET INSULIN SYRINGE 30G X 1/2" 1 ML, 31G X 15/64" 0.5 ML, 31G X 5/16" 1 ML (<i>Insulin Syringe-Needle U-100</i>)	T1	
DROPLET MICRON (<i>Insulin Pen Needle</i>)	T1	
DROPLET PEN NEEDLES 31G X 5 MM , 31G X 8 MM , 32G X 4 MM , 32G X 5 MM , 32G X 6 MM (<i>Insulin Pen Needle</i>)	T1	
EASIVENT (<i>Spacer/Aero-Holding Chambers</i>)	T1	QL (2 EA per 365 days)
<i>Easy Comfort Lancets</i>	T1	
EASY TOUCH INSULIN SYRINGE 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML (<i>Insulin Syringe-Needle U-100</i>)	T1	
EASY TOUCH PEN NEEDLES 31G X 5 MM , 31G X 8 MM (<i>Insulin Pen Needle</i>)	T1	
EMBECTA AUTOSHIELD DUO (<i>Insulin Pen Needle</i>)	T1	
EMBECTA INS SYR U/F 1/2 UNIT (<i>Insulin Syringe-Needle U-100</i>)	T1	
EMBECTA INSULIN SYR ULTRAFINE (<i>Insulin Syringe-Needle U-100</i>)	T1	
EMBECTA INSULIN SYRINGE (<i>Insulin Syringe-Needle U-100</i>)	T1	
EMBECTA INSULIN SYRINGE U-100 27G X 5/8" 1 ML (<i>Insulin Syringe-Needle U-100</i>)	T1	
EMBECTA PEN NEEDLE NANO (<i>Insulin Pen Needle</i>)	T1	
EMBECTA PEN NEEDLE NANO 2 GEN (<i>Insulin Pen Needle</i>)	T1	
EMBECTA PEN NEEDLE ULTRAFINE (<i>Insulin Pen Needle</i>)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EMBRACE LANCETS ULTRA THIN 30G (<i>Lancets</i>)	T1	
<i>EQ Space Chamber Anti-Static</i>	T1	QL (2 EA per 365 days)
FEMCAP (<i>Cervical Caps</i>)	T1	
FREESTYLE LANCETS (<i>Lancets</i>)	T1	
FREESTYLE LIBRE 14 DAY READER (<i>Continuous Glucose Receiver</i>)	T1	PA
FREESTYLE LIBRE 14 DAY SENSOR (<i>Continuous Glucose Sensor</i>)	T1	PA
FREESTYLE LIBRE 2 PLUS SENSOR (<i>Continuous Glucose Sensor</i>)	T1	PA
FREESTYLE LIBRE 2 READER (<i>Continuous Glucose Receiver</i>)	T1	PA
FREESTYLE LIBRE 2 SENSOR (<i>Continuous Glucose Sensor</i>)	T1	PA
FREESTYLE LIBRE 3 PLUS SENSOR (<i>Continuous Glucose Sensor</i>)	T1	PA
FREESTYLE LIBRE 3 READER (<i>Continuous Glucose Receiver</i>)	T1	PA
FREESTYLE LIBRE 3 SENSOR (<i>Continuous Glucose Sensor</i>)	T1	PA
GEBAUERS PAIN EASE (<i>Pentafluoroprop-Tetrafluoroeth</i>)	T1	
GEBAUERS SPRAY AND STRETCH (<i>Pentafluoroprop-Tetrafluoroeth</i>)	T1	
GELCLAIR (<i>Povidone-NaHyaluron-Glycyrrhet</i>)	T1	
<i>Heparin Sod (Pork) Lock Flush Intravenous Solution 10 UNIT/ML, 100 UNIT/ML</i>	T1	
<i>Insulin Syringe 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML, 30G X 5/16" 0.3 ML, 30G X 5/16" 0.5 ML, 30G X 5/16" 1 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 1 ML</i>	T1	
<i>Lancets 28G Thin</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Lancets Micro Thin 33G</i>	T1	
<i>Lancets Super Thin 28G</i>	T1	
<i>Lancets Ultra Thin 30G</i>	T1	
<i>Lancing Device</i>	T1	
MICROCHAMBER (<i>Spacer/Aero-Holding Chambers</i>)	T1	QL (2 EA per 365 days)
MICROLET LANCETS (<i>Lancets</i>)	T1	
NEBUSAL INHALATION NEBULIZATION SOLUTION 3 % (<i>Sodium Chloride</i>)	T1	
NOVOFINE PEN NEEDLE (<i>Insulin Pen Needle</i>)	T1	
ONETOUCH DELICA PLUS LANCET30G (<i>Lancets</i>)	T1	
ONETOUCH DELICA PLUS LANCET33G (<i>Lancets</i>)	T1	
OPTICHAMBER DIAMOND (<i>Spacer/Aero-Holding Chambers</i>)	T1	QL (2 EA per 365 days)
OPTICHAMBER DIAMOND-LG MASK (<i>Spacer/Aero-Holding Chambers</i>)	T1	QL (2 EA per 365 days)
OPTICHAMBER DIAMOND-MD MASK (<i>Spacer/Aero-Holding Chambers</i>)	T1	QL (2 EA per 365 days)
OPTICHAMBER DIAMOND-SM MASK (<i>Spacer/Aero-Holding Chambers</i>)	T1	QL (2 EA per 365 days)
ORAMAGICRX (<i>Oral Wound Care Products</i>)	T1	
POCKET CHAMBER (<i>Spacer/Aero-Holding Chambers</i>)	T1	QL (2 EA per 365 days)
<i>ProChamber VHC</i>	T1	QL (2 EA per 365 days)
QUICKVUE AT-HOME COVID-19 TEST (<i>COVID-19 At Home Test</i>)	T1	QL (8 EA per 30 days)
RADIAPLEXR (<i>Wound Dressings</i>)	T1	
REGENECARE (<i>Lidocaine-Collagen-Aloe Vera</i>)	T1	
RELION TRUE MET AIR GLUC METER (<i>Blood Glucose Monitoring Suppl</i>)	T1	QL (100 EA per 90 days)
<i>Sodium Chloride Inhalation Nebulization Solution 0.9 %, 10 %, 3 %</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Sure Comfort Insulin Syringe 28G X 1/2" 1 ML, 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML	T1	
Sure Comfort Lancets 30G	T1	
Sure Comfort Pen Needles 31G X 8 MM	T1	
TechLITE Insulin Syringe 31G X 5/16" 0.3 ML	T1	
TECHLITE PEN NEEDLES 31G X 8 MM (Insulin Pen Needle)	T1	
TRUE METRIX AIR GLUCOSE METER KIT (Blood Glucose Monitoring Suppl)	T1	QL (1 EA per 365 days)
TRUE METRIX METER KIT (Blood Glucose Monitoring Suppl)	T1	QL (1 EA per 365 days)
TRUEPLUS 5-BEVEL PEN NEEDLES 32G X 4 MM (Insulin Pen Needle)	T1	
TRUEPLUS LANCETS 28G (Lancets)	T1	
TRUEPLUS LANCETS 30G (Lancets)	T1	
TRUEPLUS LANCETS 33G (Lancets)	T1	
TRUEPLUS SAFETY LANCETS 28G (Lancets)	T1	
ULTICARE MICRO PEN NEEDLES 32G X 4 MM (Insulin Pen Needle)	T1	
UNIFINE PENTIPS PLUS 31G X 8 MM (Insulin Pen Needle)	T1	
VORTEX VALVED HOLDING CHAMBER (Spacer/Aero-Holding Chambers)	T1	QL (2 EA per 365 days)
Diagnostic Agents		
Adrenocortical Insufficiency		
CORTROPHIN (Corticotropin)	T1	PA
CORTROPHIN GEL (Corticotropin)	T1	PA
Cardiac Function		

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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Drug Tier SCO = State Carve Out T1 = Preferred Medication T2 = Preferred Medication with Restriction T3 = Non-Preferred Medication - Prior Authorization is Required		
Coverage Requirements and Limits AL = Age Limit PA = Prior Authorization QL = Quantity Limit SCO = State Carve Out ST = Step Therapy		
<i>Aspirin-Dipyridamole ER</i>	T1	
<i>Dipyridamole Oral</i>	T1	
Diabetes Mellitus		
RELION TRUE METRIX TEST STRIPS (<i>Glucose Blood</i>)	T1	QL (100 EA per 90 days)
TRUE METRIX BLOOD GLUCOSE TEST (<i>Glucose Blood</i>)	T1	QL (100 EA per 90 days)
TRUE METRIX PRO BLOOD GLUCOSE (<i>Glucose Blood</i>)	T1	QL (100 EA per 90 days)
TRUETRACK TEST (<i>Glucose Blood</i>)	T1	QL (100 EA per 90 days)
Diagnostic Agents		
BINAXNOW COVID-19 AG HOME TEST (<i>COVID-19 At Home Test</i>)	T1	QL (8 EA per 30 days)
CARESTART COVID-19 HOME TEST (<i>COVID-19 At Home Test</i>)	T1	QL (8 EA per 30 days)
<i>Ellume Covid-19 Home Test</i>	T1	QL (8 EA per 30 days)
<i>FaStep COVID-19 Antigen Test</i>	T1	QL (8 EA per 30 days)
FLOWFLEX COVID-19 AG HOME TEST (<i>COVID-19 At Home Test</i>)	T1	QL (8 EA per 30 days)
IHEALTH COVID-19 RAPID TEST (<i>COVID-19 At Home Test</i>)	T1	QL (8 EA per 30 days)
INTELISWAB COVID-19 RAPID TEST (<i>COVID-19 At Home Test</i>)	T1	QL (8 EA per 30 days)
LUCIRA CHECK IT COVID-19 TEST (<i>COVID-19 At Home Test</i>)	T1	QL (8 EA per 30 days)
QUICKVUE AT-HOME COVID-19 TEST (<i>COVID-19 At Home Test</i>)	T1	QL (8 EA per 30 days)
Myasthenia Gravis		
<i>Neostigmine Methylsulfate Intravenous Solution Prefilled Syringe 3 MG/3ML</i>	T1	PA
Pheochromocytoma		
<i>metyroSINE</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Electrolytic, Caloric, And Water Balance		
Acidifying Agents		
K-PHOS (<i>Potassium Phosphate Monobasic</i>)	T1	
K-PHOS NO 2 (<i>Pot & Sod Ac Phosphates</i>)	T1	
PHOSPHA 250 NEUTRAL (<i>K Phos Mono-Sod Phos Di & Mono</i>)	T1	
<i>Phosphorous</i>	T1	
Alkalinizing Agents		
ORACIT (<i>Sod Citrate-Citric Acid</i>)	T1	
<i>Pot & Sod Cit-Cit Ac</i>	T1	
<i>Potassium Citrate ER Oral Tablet Extended Release 10 MEQ (1080 MG), 5 MEQ (540 MG)</i>	T1	
<i>Potassium Citrate-Citric Acid Oral Solution</i>	T1	
<i>Sod Citrate-Citric Acid Oral Solution 500-334 MG/5ML</i>	T1	
<i>Tricitrates</i>	T1	
Ammonia Detoxicants		
<i>Constulose</i>	T1	
<i>Enulose</i>	T1	
<i>Generlac</i>	T1	
<i>Lactulose Encephalopathy Oral Solution 10 GM/15ML</i>	T1	
<i>Lactulose Oral Solution</i>	T1	
LITHOSTAT (<i>Acetohydroxamic Acid</i>)	T1	PA
<i>Sodium Phenylbutyrate Oral Powder 3 GM/TSP</i>	T1	
<i>Sodium Phenylbutyrate Oral Tablet</i>	T1	
Caloric Agents		
<i>BUPivacaine in Dextrose Intrathecal</i>	T1	
<i>Bupivacaine Spinal</i>	T1	
<i>CVS Jock Itch</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ELLIOTTS B (<i>Intrathecal Elec-Dextrose</i>)	T1	
NUTRIVIT (<i>B Complex-Lysine-Min-Fe-FA</i>)	T1	
Carbonic Anhydrase Inhibitors (40:28)		
<i>acetaZOLAMIDE ER</i>	T1	
<i>acetaZOLAMIDE Oral</i>	T1	
Diuretics, Miscellaneous		
THEO-24 (<i>Theophylline</i>)	T1	
<i>Theophylline ER Oral Tablet Extended Release 12 Hour 300 MG, 450 MG</i>	T1	
<i>Theophylline ER Oral Tablet Extended Release 24 Hour</i>	T1	
<i>Theophylline Oral Elixir</i>	T1	
Irrigating Solutions		
<i>Acetic Acid Glacial Solution 99 %</i>	T1	
<i>Acetic Acid Irrigation</i>	T1	
<i>Acetic Acid Solution 5 %</i>	T1	
ARGYLE STERILE SALINE (<i>Sodium Chloride (GU Irrigant)</i>)	T1	
<i>Glycine Irrigation</i>	T1	
<i>Glycine Urologic</i>	T1	
<i>Lactated Ringers Irrigation</i>	T1	
PHYSIOLYTE (<i>Irrigation Solns Physiological</i>)	T1	
<i>Ringers Irrigation</i>	T1	
<i>Sodium Chloride Irrigation Solution 0.9 %</i>	T1	
<i>Sorbitol-Mannitol</i>	T1	
<i>Sterile Water for Irrigation</i>	T1	
<i>Water For Irrigation, Sterile</i>	T1	
Loop Diuretics (40:28)		
<i>Bumetanide Oral</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Ethacrynic Acid Oral</i>	T1	
<i>Furosemide Oral Solution 10 MG/ML, 8 MG/ML</i>	T1	
<i>Furosemide Oral Tablet</i>	T1	
<i>Torsemide Oral</i>	T1	
Osmotic Diuretics (40:28)		
<i>Sorbitol-Mannitol</i>	T1	
Phosphate-Removing Agents		
<i>Calcium Acetate (Phos Binder)</i>	T1	
<i>Calcium Acetate Oral Tablet 667 MG</i>	T1	
<i>Lanthanum Carbonate</i>	T1	PA
<i>Sevelamer Carbonate Oral Tablet</i>	T1	
<i>Sevelamer HCl</i>	T1	PA
Potassium-Removing Agents		
LOKELMA (<i>Sodium Zirconium Cyclosilicate</i>)	T1	QL (30 EA per 30 days)
VELTASSA ORAL PACKET 1 GM (<i>Patiromer Sorbitex Calcium</i>)	T1	ST; QL (60 EA per 30 days)
VELTASSA ORAL PACKET 16.8 GM, 25.2 GM, 8.4 GM (<i>Patiromer Sorbitex Calcium</i>)	T1	ST; QL (30 EA per 30 days)
Potassium-Sparing Diuretics (40:28)		
<i>aMILoride HCl Oral</i>	T1	
<i>aMILoride-hydroCHLOROthiazide</i>	T1	
<i>Eplerenone</i>	T1	PA
<i>Spironolactone Oral Tablet</i>	T1	
<i>Spironolactone-HCTZ</i>	T1	
<i>Triamterene Oral</i>	T1	PA
<i>Triamterene-HCTZ Oral Capsule 37.5-25 MG</i>	T1	
<i>Triamterene-HCTZ Oral Tablet</i>	T1	
Replacement Preparations		

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Actical	T1	
B-Complex/Vitamin C	T1	
Bupivacaine HCl-NaCl Epidural Solution 0.125-0.9 %	T1	
Calcium Acetate (Phos Binder)	T1	
Calcium Acetate Oral Tablet 667 MG	T1	
Centravites 50 Plus	T1	
Classic Prenatal	T1	
Complete Natal DHA Oral 29-1-200 & 200 MG	T1	
CVS One Daily Essential	T1	
DIALYVITE 3000 (B Complex-C-Biotin-E-Min-FA)	T1	
DIALYVITE/ZINC (B Complex-C-Zn-Folic Acid)	T1	
EFFER-K ORAL TABLET EFFERVESCENT 25 MEQ (Potassium Bicarbonate)	T1	
ELLIOTTS B (Intrathecal Elec-Dextrose)	T1	
EQL Prenatal Formula	T1	
Essential One Daily Multivit	T1	
Fentanyl Cit-Ropivacaine-NaCl Epidural Solution 0.2-0.2-0.9 MG/100ML-%, 0.5-0.2-0.9 MG/250ML-%	T1	
Fentanyl-Bupivacaine-NaCl Epidural Solution 0.2-0.1-0.9 MG/100ML-%, 0.2-0.125-0.9 MG/100ML-%, 0.5-0.1-0.9 MG/250ML-%, 0.5-0.125-0.9 MG/250ML-%	T1	
GALZIN (Zinc Acetate (Oral))	T1	PA
GNP PreNatal	T1	
GUMMI BEAR MULTIVITAMIN/MIN (Pediatric Multivit-Minerals)	T1	
Hematinic Plus Vit/Minerals	T1	
INFASURF INTRATRACHEAL (Calfactant in NaCl)	T1	
Potassium Chloride Crys ER (Klor-Con M10)	T1	
Potassium Chloride Crys ER (Klor-Con M20)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Potassium Chloride (Klor-Con Oral Packet 20 Meq)	T1	PA
K-PHOS (Potassium Phosphate Monobasic)	T1	
Lactated Ringers Irrigation	T1	
LYSIPLEX PLUS ORAL LIQUID (Multiple Vitamins-Minerals)	T1	
Magnesium Chloride Injection	T1	
Magnesium Oral Tablet 400 MG	T1	
MAGNESIUM-OXIDE ORAL TABLET 400 (240 MG) MG (Magnesium Oxide)	T1	
MgO Oral Tablet 400 (240 Mg) MG	T1	
M-Natal Plus	T1	
NEBUSAL INHALATION NEBULIZATION SOLUTION 3 % (Sodium Chloride)	T1	
NUTRIVIT (B Complex-Lysine-Min-Fe-FA)	T1	
PHOSPHA 250 NEUTRAL (K Phos Mono-Sod Phos Di & Mono)	T1	
Phosphorous	T1	
PHOSPHO-TRIN K500 (Potassium Phosphate Monobasic)	T1	
Potassium Chloride Crys ER	T1	
Potassium Chloride ER	T1	
Potassium Chloride Oral Packet 20 MEQ	T1	PA
Potassium Chloride Oral Solution 10 %, 20 MEQ/15ML (10%), 40 MEQ/15ML (20%)	T1	
Prenatal Gummies/DHA & FA	T1	
PRENATAL MULTIVITAMIN + DHA (Prenatal MV-Min-Fe Fum-FA-DHA)	T1	
Prenatal One Daily	T1	
Prenatal Oral Tablet 27-0.8 MG, 27-1 MG, 28-0.8 MG	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Prenatal Plus</i>	T1	
<i>Prenatal Vitamins Oral Tablet 28-0.8 MG</i>	T1	
<i>Prenatal/Iron Oral Tablet</i>	T1	
<i>Ropivacaine HCl-NaCl Injection Solution 0.2-0.9 %</i>	T1	
<i>Saline Bacteriostatic</i>	T1	
<i>Sodium Chloride (PF)</i>	T1	
<i>Sodium Chloride Bacteriostatic</i>	T1	
<i>Sodium Chloride Inhalation Nebulization Solution 0.9 %, 10 %, 3 %</i>	T1	
<i>Sodium Chloride Injection Solution 2.5 MEQ/ML</i>	T1	
<i>Stress Formula</i>	T1	
<i>Support</i>	T1	
SUPPORT-500 (<i>Multiple Vitamins-Minerals</i>)	T1	
<i>V-C Forte</i>	T1	
VIC-FORTE (<i>Multiple Vitamins-Minerals</i>)	T1	
VITALETS CHILDRENS ORAL TABLET CHEWABLE (<i>Pediatric Multivit-Minerals</i>)	T1	
<i>Wes-Phos 250 Neutral</i>	T1	
<i>WesTab Plus</i>	T1	
Salt And Sugar Substitutes		
<i>Aspartame (For Compounding)</i>	T1	
Thiazide Diuretics (40:28)		
<i>aMILoride-hydroCHLOROthiazide</i>	T1	
<i>Benazepril-hydroCHLOROthiazide</i>	T1	
<i>Bisoprolol-hydroCHLOROthiazide</i>	T1	
<i>Candesartan Cilexetil-HCTZ Oral Tablet 16-12.5 MG, 32-12.5 MG</i>	T1	PA
<i>Captopril-hydroCHLOROthiazide</i>	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIURIL (<i>Chlorothiazide</i>)	T1	
<i>Enalapril-Hydrochlorothiazide Oral Tablet 10-25 MG</i>	T1	
<i>Enalapril-Hydrochlorothiazide Oral Tablet 5-12.5 MG</i>	T1	PA
<i>Fosinopril Sodium-HCTZ</i>	T1	PA
<i>hydroCHLOROthiazide Oral</i>	T1	
<i>Irbesartan-hydroCHLOROthiazide</i>	T1	
<i>Lisinopril-hydroCHLOROthiazide</i>	T1	
<i>Losartan Potassium-HCTZ</i>	T1	
<i>Metoprolol-hydroCHLOROthiazide</i>	T1	PA
<i>Olmesartan Medoxomil-HCTZ</i>	T1	
<i>Quinapril-hydroCHLOROthiazide</i>	T1	
<i>Spironolactone-HCTZ</i>	T1	
<i>Telmisartan-HCTZ</i>	T1	PA
<i>Triamterene-HCTZ Oral Capsule 37.5-25 MG</i>	T1	
<i>Triamterene-HCTZ Oral Tablet</i>	T1	
<i>Valsartan-hydroCHLOROthiazide</i>	T1	
Thiazide-Like Diuretics (40:28)		
<i>Atenolol-Chlorthalidone</i>	T1	
<i>Chlorthalidone Oral Tablet 25 MG, 50 MG</i>	T1	
<i>Indapamide Oral</i>	T1	
<i>metOLazone</i>	T1	
THALITONE (<i>Chlorthalidone</i>)	T1	
Uricosuric Agents		
<i>Colchicine-Probenecid</i>	T1	
<i>Probenecid Oral</i>	T1	
Enzymes		
Enzyme Inhibitors		

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Nitisinone Oral Capsule 10 MG, 2 MG, 5 MG</i>	T1	
Enzymes		
AMPHADASE (<i>Hyaluronidase Bovine</i>)	T1	
CREON (<i>Pancrelipase (Lip-Prot-Amyl)</i>)	T1	
PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML (<i>Dornase Alfa</i>)	T1	PA
SANTYL (<i>Collagenase</i>)	T1	
SUCRAID (<i>Sacrosidase</i>)	T1	
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 10000-32000 UNIT, 15000-47000 UNIT, 20000-63000 UNIT, 25000-79000 UNIT, 3000-10000 UNIT, 40000-126000 UNIT, 5000-24000 UNIT, 60000-189600 UNIT (<i>Pancrelipase (Lip-Prot-Amyl)</i>)	T1	
Eye, Ear, Nose And Throat (Eent) Preps.		
Alpha-Adrenergic Agonists (52:40)		
<i>Apraclonidine HCl</i>	T1	
<i>Brimonidine Tartrate Ophthalmic Solution 0.15 %</i>	T1	PA
<i>Brimonidine Tartrate Ophthalmic Solution 0.2 %</i>	T1	
<i>Brimonidine Tartrate-Timolol</i>	T1	PA
IOPIDINE OPHTHALMIC SOLUTION 1 % (<i>Apraclonidine HCl</i>)	T1	
Antiallergic Agents		
ALOCRIAL (<i>Nedocromil Sodium</i>)	T1	
<i>Azelastine HCl Nasal Solution 0.1 %, 137 MCG/SPRAY</i>	T1	
<i>Azelastine HCl Ophthalmic</i>	T1	QL (6 ML per 30 days)
<i>Cromolyn Sodium Inhalation</i>	T1	
<i>Cromolyn Sodium Ophthalmic</i>	T1	
<i>Cromolyn Sodium Oral</i>	T1	
<i>Epinastine HCl</i>	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Olopatadine HCl Ophthalmic</i>	T1	
Antibacterials (52:04)		
<i>Bacitracin Ophthalmic</i>	T1	
<i>Bacitracin-Polymyxin B Ophthalmic Ointment 500-10000 UNIT/GM</i>	T1	
<i>Bacitra-Neomycin-Polymyxin-HC</i>	T1	
CILOXAN OPHTHALMIC OINTMENT (<i>Ciprofloxacin HCl</i>)	T1	
<i>Ciprofloxacin HCl Ophthalmic</i>	T1	
<i>Ciprofloxacin-Dexamethasone</i>	T1	
<i>Ciprofloxacin-Hydrocortisone</i>	T1	
CORTISPORIN-TC (<i>Neomycin-Colist-HC-Thonzonium</i>)	T1	
<i>Doxycycline Hyclate Oral Tablet 20 MG</i>	T1	PA
<i>EQL Bacitracin Zinc</i>	T1	
<i>Ery</i>	T1	
<i>Erythromycin External Gel</i>	T1	
<i>Erythromycin External Solution</i>	T1	
<i>Erythromycin Ophthalmic</i>	T1	
<i>Gentamicin Sulfate External</i>	T1	
<i>Gentamicin Sulfate Ophthalmic Solution</i>	T1	
<i>Minocycline HCl Oral Capsule 100 MG</i>	T1	QL (60 EA per 30 days)
<i>Minocycline HCl Oral Capsule 50 MG</i>	T1	
<i>Moxifloxacin HCl (2X Day)</i>	T1	PA
<i>Moxifloxacin HCl Ophthalmic Solution</i>	T1	
<i>Neomycin Sulfate Oral</i>	T1	
<i>Neomycin-Bacitracin Zn-Polymyx Ophthalmic Ointment 5-400-10000</i>	T1	
<i>Neomycin-Polymyxin-Dexameth</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Neomycin-Polymyxin-Gramicidin Ophthalmic Solution 1.75-10000-.025</i>	T1	
<i>Neomycin-Polymyxin-HC Ophthalmic Suspension 3.5-10000-1</i>	T1	
<i>Neomycin-Polymyxin-HC Otic</i>	T1	
<i>Ofloxacin Ophthalmic</i>	T1	
<i>Ofloxacin Otic</i>	T1	
<i>Polymyxin B-Trimethoprim</i>	T1	
<i>Sulfacetamide Sodium Ophthalmic Solution</i>	T1	
<i>Sulfacetamide-prednisolONE Ophthalmic Solution</i>	T1	
TOBRADEX OPHTHALMIC OINTMENT (<i>Tobramycin-Dexamethasone</i>)	T1	
<i>Tobramycin Inhalation Nebulization Solution 300 MG/5ML</i>	T1	PA
<i>Tobramycin Ophthalmic</i>	T1	
<i>Tobramycin-Dexamethasone</i>	T1	
TOBEX OPHTHALMIC OINTMENT (<i>Tobramycin</i>)	T1	
ZYLET (<i>Loteprednol-Tobramycin</i>)	T1	
Antifungals (Eent)		
NATACYN (<i>Natamycin</i>)	T1	
Antiglaucoma Agents, Miscellaneous		
<i>EPINEPHrine (Anaphylaxis) Injection Solution 30 MG/30ML</i>	T1	
<i>EPINEPHrine Injection Solution 1 MG/ML</i>	T1	
<i>EPINEPHrine PF Injection Solution</i>	T1	
ROCKLATAN (<i>Netarsudil-Latanoprost</i>)	T1	PA
Anti-Infectives, Miscellaneous (52:04)		
<i>Acetic Acid Otic</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETADINE OPHTHALMIC PREP (<i>Povidone-Iodine</i>)	T1	
<i>Chlorhexidine Gluconate Mouth/Throat</i>	T1	
<i>Hydrocortisone-Acetic Acid</i>	T1	
<i>Chlorhexidine Gluconate</i> (Periogard)	T1	
<i>Silver Nitrate External Solution 0.5 %</i>	T1	
Anti-Inflammatory Agents (Eent)		
CEQUA (<i>CycloSPORINE</i>)	T1	PA
<i>CycloSPORINE Modified</i>	T1	
<i>cycloSPORINE Ophthalmic</i>	T1	PA
<i>CycloSPORINE Oral Capsule</i>	T1	
<i>CycloSPORINE Modified</i> (Gengraf Oral Capsule 100 Mg, 25 Mg)	T1	
<i>CycloSPORINE Modified</i> (Gengraf Oral Solution)	T1	
NEORAL (<i>CycloSPORINE Modified</i>)	T1	
SANDIMMUNE ORAL CAPSULE (<i>CycloSPORINE</i>)	T1	
XIIDRA (<i>Lifitegrast</i>)	T1	PA
Antivirals (Eent)		
<i>Trifluridine Ophthalmic</i>	T1	
Astringents (52:04)		
<i>Chlorhexidine Gluconate Mouth/Throat</i>	T1	
<i>Chlorhexidine Gluconate</i> (Periogard)	T1	
Beta-Adrenergic Blocking Agents (52:40)		
<i>Betaxolol HCl Ophthalmic</i>	T1	PA
BETIMOL OPHTHALMIC SOLUTION 0.5 % (<i>Timolol Hemihydrate</i>)	T1	
BETOPTIC-S (<i>Betaxolol HCl</i>)	T1	PA
<i>Brimonidine Tartrate-Timolol</i>	T1	PA
<i>Carteolol HCl</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Dorzolamide HCl-Timolol Mal</i>	T1	
<i>Levobunolol HCl Ophthalmic Solution 0.5 %</i>	T1	
<i>Timolol Maleate (Once-Daily)</i>	T1	
<i>Timolol Maleate</i> (Timolol Maleate OcuDose)	T1	
<i>Timolol Maleate Ophthalmic</i>	T1	
<i>Timolol Maleate PF</i>	T1	
Carbonic Anhydrase Inhibitors (52:40)		
<i>acetaZOLAMIDE ER</i>	T1	
<i>acetaZOLAMIDE Oral</i>	T1	
<i>Brinzolamide</i>	T1	PA
<i>Dorzolamide HCl Ophthalmic</i>	T1	
<i>Dorzolamide HCl-Timolol Mal</i>	T1	
<i>methazolAMIDE Oral</i>	T1	PA
Corticosteroids (Eent)		
<i>Ala-Cort External Cream 1 %</i>	T1	
ALREX (<i>Loteprednol Etabonate</i>)	T1	
<i>Anucort-HC</i>	T1	
ANUSOL-HC EXTERNAL (<i>Hydrocortisone</i>)	T1	
<i>Bacitra-Neomycin-Polymyxin-HC</i>	T1	
<i>Ciprofloxacin-Dexamethasone</i>	T1	
<i>Ciprofloxacin-Hydrocortisone</i>	T1	
CORTANE-B EXTERNAL (<i>HC-Pramoxine-Chloroxylonol</i>)	T1	
CORTIFOAM EXTERNAL (<i>Hydrocortisone Acetate</i>)	T1	PA
CORTISPORIN-TC (<i>Neomycin-Colist-HC-Thonzonium</i>)	T1	
DEXAMETHASONE INTENSOL (<i>Dexamethasone</i>)	T1	
<i>Dexamethasone Oral Elixir</i>	T1	
<i>Dexamethasone Oral Solution</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Dexamethasone Oral Tablet</i>	T1	
<i>Dexamethasone Oral Tablet Therapy Pack 1.5 MG (51)</i>	T1	
<i>Dexamethasone Sodium Phosphate Ophthalmic</i>	T1	
<i>Difluprednate</i>	T1	ST; QL (5 ML per 30 days)
FLAREX (<i>Fluorometholone Acetate</i>)	T1	
<i>Flunisolide Nasal Solution 25 MCG/ACT (0.025%)</i>	T1	PA
<i>Fluocinolone Acetonide Body</i>	T1	
<i>Fluocinolone Acetonide External</i>	T1	
<i>Fluocinolone Acetonide Scalp</i>	T1	
<i>Fluorometholone Ophthalmic</i>	T1	
<i>Fluticasone Furoate Ellipta</i>	T1	
<i>Fluticasone Furoate-Vilanterol Inhalation Aerosol Powder Breath Activated 100-25 MCG/ACT, 200-25 MCG/ACT</i>	T1	
<i>Fluticasone Propionate Diskus</i>	T1	
<i>Fluticasone Propionate HFA</i>	T1	
<i>Fluticasone Propionate Nasal</i>	T1	
<i>Fluticasone-Salmeterol Inhalation Aerosol</i>	T1	PA
<i>Fluticasone-Salmeterol Inhalation Aerosol Powder Breath Activated 100-50 MCG/ACT, 113-14 MCG/ACT, 232-14 MCG/ACT, 250-50 MCG/ACT, 500-50 MCG/ACT, 55-14 MCG/ACT</i>	T1	
FML FORTE (<i>Fluorometholone</i>)	T1	
<i>Hydrocortisone (Perianal)</i>	T1	
<i>Hydrocortisone Ace-Pramoxine External Cream 1-1 %</i>	T1	
<i>Hydrocortisone Acetate Rectal</i>	T1	
<i>Hydrocortisone Butyrate External Cream</i>	T1	PA
<i>Hydrocortisone Butyrate External Ointment</i>	T1	PA
<i>Hydrocortisone Butyrate External Solution</i>	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Hydrocortisone External Cream 1 %, 2.5 %</i>	T1	
<i>Hydrocortisone External Lotion 2.5 %</i>	T1	
<i>Hydrocortisone External Ointment 1 %, 2.5 %</i>	T1	
<i>Hydrocortisone Oral</i>	T1	
<i>Hydrocortisone Rectal Enema</i>	T1	
<i>Hydrocortisone Valerate</i>	T1	PA
<i>Hydrocortisone-Acetic Acid</i>	T1	
<i>Hydrocort-Pramoxine (Perianal)</i>	T1	
<i>Loteprednol Etabonate Ophthalmic Suspension 0.5 %</i>	T1	
MAXIDEX (<i>Dexamethasone</i>)	T1	
<i>Mometasone Furoate External</i>	T1	
<i>Neomycin-Polymyxin-Dexameth</i>	T1	
<i>Neomycin-Polymyxin-HC Ophthalmic Suspension 3.5-10000-1</i>	T1	
<i>Neomycin-Polymyxin-HC Otic</i>	T1	
PRED MILD (<i>PrednisoLONE Acetate</i>)	T1	
<i>prednisoLONE Acetate Ophthalmic</i>	T1	
<i>prednisoLONE Oral Solution</i>	T1	
<i>prednisoLONE Oral Tablet</i>	T1	
<i>PrednisoLONE Sodium Phosphate Ophthalmic</i>	T1	
<i>prednisoLONE Sodium Phosphate Oral Solution 15 MG/5ML, 5 MG/5ML</i>	T1	
PROCTOFOAM HC EXTERNAL (<i>Hydrocortisone Ace-Pramoxine</i>)	T1	PA
<i>Hydrocortisone</i> (Procto-Med Hc External)	T1	
<i>Hydrocortisone</i> (Proctosol Hc External)	T1	
<i>Hydrocortisone</i> (Proctozone-Hc External)	T1	
<i>Sulfacetamide-prednisoLONE Ophthalmic Solution</i>	T1	

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bold italics = Generic drugs UPPERCASE = Brand name drugs	Drug Tier	Coverage Requirements and Limits
	SCO = State Carve Out T1 = Preferred Medication T2 = Preferred Medication with Restriction T3 = Non-Preferred Medication - Prior Authorization is Required	AL = Age Limit PA = Prior Authorization QL = Quantity Limit SCO = State Carve Out ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TEXACORT (<i>Hydrocortisone</i>)	T1	
TOBRADEX OPHTHALMIC OINTMENT (<i>Tobramycin-Dexamethasone</i>)	T1	
<i>Tobramycin-Dexamethasone</i>	T1	
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT (<i>Fluticasone-Umeclidin-Vilant</i>)	T1	PA
<i>Fluticasone-Salmeterol</i> (Wixela Inhub Inhalation Aerosol Powder Breath Activated 100-50 Mcg/Act, 250-50 Mcg/Act, 500-50 Mcg/Act)	T1	
ZYLET (<i>Loteprednol-Tobramycin</i>)	T1	
Eent Anti-Inflammatory Agents, Misc.		
CEQUA (<i>CycloSPORINE</i>)	T1	PA
<i>cycloSPORINE Ophthalmic</i>	T1	PA
XIIDRA (<i>Lifitegrast</i>)	T1	PA
Eent Drugs, Miscellaneous		
<i>Acetic Acid Otic</i>	T1	
AMVISC INTRAOCULAR SOLUTION PREFILLED SYRINGE (<i>Sodium Hyaluronate</i>)	T1	
<i>Apraclonidine HCl</i>	T1	
<i>Carteolol HCl</i>	T1	
<i>Cromolyn Sodium Inhalation</i>	T1	
<i>Cromolyn Sodium Ophthalmic</i>	T1	
<i>Cromolyn Sodium Oral</i>	T1	
DEBACTEROL (<i>Sulfuric Acid-Sulf Phenolics</i>)	T1	
GELFILM OPHTHALMIC (<i>Gelatin Adsorbable</i>)	T1	PA
<i>Hydrocortisone-Acetic Acid</i>	T1	
IOPIDINE OPHTHALMIC SOLUTION 1 % (<i>Apraclonidine HCl</i>)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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Drug Tier SCO = State Carve Out T1 = Preferred Medication T2 = Preferred Medication with Restriction T3 = Non-Preferred Medication - Prior Authorization is Required		
Coverage Requirements and Limits AL = Age Limit PA = Prior Authorization QL = Quantity Limit SCO = State Carve Out ST = Step Therapy		
<i>Ipratropium Bromide Nasal</i>	T1	
<i>Polysorbate 80</i>	T1	
TYRVAYA (<i>Varenicline Tartrate</i>)	T1	PA
Eent Nonsteroidal Anti-Inflam. Agents		
<i>Diclofenac Sodium Ophthalmic</i>	T1	
<i>Flurbiprofen Oral Tablet 100 MG</i>	T1	PA
<i>Flurbiprofen Sodium</i>	T1	
<i>Ketorolac Tromethamine Intramuscular Solution 60 MG/2ML</i>	T1	
<i>Ketorolac Tromethamine Ophthalmic</i>	T1	
<i>Ketorolac Tromethamine Oral</i>	T1	PA
Local Anesthetics (Eent)		
<i>Lidocaine HCl</i> (Glydo External Prefilled Syringe)	T1	
<i>Lidocaine HCl External Solution</i>	T1	PA
<i>Lidocaine HCl Urethral/Mucosal External Prefilled Syringe</i>	T1	
<i>Lidocaine Viscous HCl</i>	T1	
<i>Proparacaine HCl Ophthalmic</i>	T1	
<i>Tetracaine HCl Ophthalmic</i>	T1	
Miotics		
MIOCHOL-E (<i>Acetylcholine Chloride</i>)	T1	PA
MIOSTAT (<i>Carbachol</i>)	T1	PA
<i>Pilocarpine HCl Ophthalmic Solution 1 %, 2 %, 4 %</i>	T1	
<i>Pilocarpine HCl Oral Tablet 5 MG</i>	T1	
<i>Pilocarpine HCl Oral Tablet 7.5 MG</i>	T1	PA
Mydriatics		
<i>Atropine Sulfate Injection Solution 8 MG/20ML</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Atropine Sulfate Injection Solution Prefilled Syringe 0.25 MG/5ML, 0.5 MG/5ML, 1 MG/10ML</i>	T1	
<i>Atropine Sulfate Ophthalmic Solution 1 %</i>	T1	
CYCLOMYDRIL (<i>Cyclopentolate-Phenylephrine</i>)	T1	
<i>Cyclopentolate HCl Ophthalmic Solution 1 %</i>	T1	
<i>EPINEPHrine (Anaphylaxis) Injection Solution 30 MG/30ML</i>	T1	
<i>EPINEPHrine Injection Solution 1 MG/ML</i>	T1	
<i>EPINEPHrine PF Injection Solution</i>	T1	
HOMATROPAIRE (<i>Homatropine HBr</i>)	T1	
<i>Phenylephrine HCl Ophthalmic Solution 10 %, 2.5 %</i>	T1	
<i>Tropicamide Ophthalmic</i>	T1	
Prostaglandin Analogs		
<i>Bimatoprost Ophthalmic Solution 0.03 %</i>	T1	PA
<i>Latanoprost Ophthalmic</i>	T1	
LUMIGAN OPHTHALMIC SOLUTION 0.01 % (<i>Bimatoprost</i>)	T1	PA
ROCKLATAN (<i>Netarsudil-Latanoprost</i>)	T1	PA
<i>Travoprost (BAK Free)</i>	T1	PA
Rho Kinase Inhibitors		
ROCKLATAN (<i>Netarsudil-Latanoprost</i>)	T1	PA
Vasoconstrictors		
CYCLOMYDRIL (<i>Cyclopentolate-Phenylephrine</i>)	T1	
<i>EPINEPHrine (Anaphylaxis) Injection Solution 30 MG/30ML</i>	T1	
<i>EPINEPHrine Injection Solution 1 MG/ML</i>	T1	
<i>EPINEPHrine PF Injection Solution</i>	T1	
<i>Phenylephrine HCl Ophthalmic Solution 10 %, 2.5 %</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Gastrointestinal Drugs		
5-Ht3 Receptor Antagonists		
AKYNZEO ORAL (<i>Netupitant-Palonosetron</i>)	T1	PA
<i>Granisetron HCl Intravenous Solution 1 MG/ML, 4 MG/4ML</i>	T1	PA
<i>Granisetron HCl Oral</i>	T1	ST; QL (12 EA per 30 days)
<i>Ondansetron HCl Oral Solution 4 MG/5ML</i>	T1	
<i>Ondansetron HCl Oral Tablet 4 MG, 8 MG</i>	T1	
<i>Ondansetron Oral Tablet Dispersible 4 MG, 8 MG</i>	T1	
Antacids And Adsorbents		
<i>Magnesium Oral Tablet 400 MG</i>	T1	
<i>Magnesium Oxide Oral Tablet 400 MG</i>	T1	
<i>Omeprazole-Sodium Bicarbonate Oral Capsule 20-1100 MG</i>	T1	
Antidiarrhea Agents		
<i>Diphenoxylate-Atropine Oral Liquid</i>	T1	
<i>Diphenoxylate-Atropine Oral Tablet 2.5-0.025 MG</i>	T1	
<i>Loperamide HCl Oral Capsule</i>	T1	
MOTOFEN (<i>Difenoxin-Atropine</i>)	T1	
<i>Opium</i>	T1	PA
Antiemetics, Miscellaneous		
AKYNZEO ORAL (<i>Netupitant-Palonosetron</i>)	T1	PA
<i>Dronabinol</i>	T1	PA
<i>OLANZapine Oral Tablet</i>	T1	QL (30 EA per 30 days)
<i>Promethazine HCl Oral Solution 6.25 MG/5ML</i>	T1	
<i>Promethazine HCl Oral Tablet</i>	T1	
<i>Promethazine HCl Rectal Suppository 12.5 MG, 25 MG</i>	T1	
PROMETHEGAN (<i>Promethazine HCl</i>)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antihistamines (Gi Drugs)		
<i>Prochlorperazine</i> (Compro)	T1	
<i>Meclizine HCl Oral Tablet 12.5 MG, 25 MG</i>	T1	
<i>Meclizine HCl Oral Tablet Chewable</i>	T1	
<i>Prochlorperazine</i>	T1	
<i>Prochlorperazine Maleate Oral</i>	T1	
TIGAN INTRAMUSCULAR (<i>Trimethobenzamide HCl</i>)	T1	
<i>Trimethobenzamide HCl Oral</i>	T1	
Anti-Inflammatory Agents (Gi Drugs)		
<i>Alosetron HCl</i>	T1	PA
<i>Balsalazide Disodium</i>	T1	
<i>Mesalamine ER Oral Capsule Extended Release 24 Hour</i>	T1	
<i>Mesalamine Oral</i>	T1	
<i>Mesalamine Rectal</i>	T1	
SFROWASA (<i>Mesalamine</i>)	T1	
<i>sulfaSALazine Oral</i>	T1	
Antiulcer Agents And Acid Suppressants		
<i>Amoxicillin Oral Capsule</i>	T1	
<i>Amoxicillin Oral Suspension Reconstituted</i>	T1	
<i>Amoxicillin Oral Tablet</i>	T1	
<i>Amoxicillin Oral Tablet Chewable 125 MG, 250 MG</i>	T1	
<i>Clarithromycin ER</i>	T1	PA
<i>Clarithromycin Oral Suspension Reconstituted</i>	T1	PA
<i>Clarithromycin Oral Tablet</i>	T1	
<i>Magnesium Oxide Oral Tablet 400 MG</i>	T1	
<i>metroNIDAZOLE Oral Capsule</i>	T1	
<i>metroNIDAZOLE Oral Tablet 250 MG, 500 MG</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Tetracycline HCl Oral Capsule</i>	T1	
Cathartics And Laxatives		
<i>GAVILYTE-C (PEG 3350-KCl-NaBcb-NaCl-NaSulf)</i>	T1	
<i>PEG 3350-KCl-NaBcb-NaCl-NaSulf (Gavilyte-G)</i>	T1	
<i>PEG 3350-KCl-Na Bicarb-NaCl (Gavilyte-N With Flavor Pack)</i>	T1	
<i>Lubiprostone</i>	T1	PA
<i>Na Sulfate-K Sulfate-Mg Sulf Oral Solution 17.5-3.13-1.6 GM/177ML</i>	T1	
<i>PEG 3350-KCl-Na Bicarb-NaCl</i>	T1	
<i>PEG-3350/Electrolytes</i>	T1	
<i>PLURONIC F127 POWDER (Poloxamer)</i>	T1	
<i>Sorbitol Solution 70 %</i>	T1	
<i>SUTAB (Sodium Sulfate-Mag Sulfate-KCl)</i>	T1	
Chloride Channel Activators		
<i>Lubiprostone</i>	T1	PA
Cholelitholytic Agents		
<i>Ursodiol Oral Capsule 300 MG</i>	T1	
<i>Ursodiol Oral Tablet</i>	T1	
Digestants		
<i>CREON (Pancrelipase (Lip-Prot-Amyl))</i>	T1	
<i>ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 10000-32000 UNIT, 15000-47000 UNIT, 20000-63000 UNIT, 25000-79000 UNIT, 3000-10000 UNIT, 40000-126000 UNIT, 5000-24000 UNIT, 60000-189600 UNIT (Pancrelipase (Lip-Prot-Amyl))</i>	T1	
Dopamine Receptor Antagonists		
<i>Promethazine HCl Rectal Suppository 12.5 MG, 25 MG</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROMETHEGAN (<i>Promethazine HCl</i>)	T1	
Gi Drugs, Miscellaneous		
<i>Adalimumab-aaty (1 Pen) Subcutaneous Auto-Injector Kit 40 MG/0.4ML</i>	T1	QL (4 EA per 28 days)
<i>Adalimumab-aaty (1 Pen) Subcutaneous Auto-Injector Kit 80 MG/0.8ML</i>	T1	QL (2 EA per 28 days)
<i>Adalimumab-aaty (2 Pen)</i>	T1	QL (2 EA per 28 days)
<i>Adalimumab-aaty (2 Syringe)</i>	T1	QL (2 EA per 28 days)
<i>Adalimumab-aaty CD/UC/HS Start</i>	T1	QL (2 EA per 28 days)
<i>Adalimumab-fkjp (2 Pen)</i>	T1	QL (4 EA per 28 days)
<i>Adalimumab-fkjp (2 Syringe)</i>	T1	QL (4 EA per 28 days)
AVSOLA (<i>inFLIXimab-axxq</i>)	T1	PA
<i>Dronabinol</i>	T1	PA
ENTYVIO INTRAVENOUS (<i>Vedolizumab</i>)	T1	PA
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML (<i>Adalimumab-bwwd</i>)	T1	QL (1.6 ML per 28 days)
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.8ML (<i>Adalimumab-bwwd</i>)	T1	QL (3.2 ML per 28 days)
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML (<i>Adalimumab-bwwd</i>)	T1	QL (1.6 ML per 28 days)
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.8ML (<i>Adalimumab-bwwd</i>)	T1	QL (3.2 ML per 28 days)
IBSRELA (<i>Tenapanor HCl</i>)	T1	PA
INFLECTRA (<i>InFLIXimab-dyyb</i>)	T1	PA
<i>inFLIXimab</i>	T1	PA
LINZESS (<i>Linacotide</i>)	T1	PA
<i>Lubiprostone</i>	T1	PA
MOVANTIK (<i>Naloxegol Oxalate</i>)	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Octreotide Acetate Injection Solution 100 MCG/ML, 1000 MCG/ML, 200 MCG/ML, 50 MCG/ML, 500 MCG/ML</i>	T1	
<i>Prucalopride Succinate</i>	T1	PA
RELISTOR ORAL (<i>Methylnaltrexone Bromide</i>)	T1	PA
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML (<i>Methylnaltrexone Bromide</i>)	T1	PA
RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>Methylnaltrexone Bromide</i>)	T1	PA
RENFLEXIS (<i>InFLIXimab-abda</i>)	T1	PA
SIMLANDI (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML (<i>Adalimumab-ryvk</i>)	T1	QL (4 EA per 28 days)
SIMLANDI (2 PEN) (<i>Adalimumab-ryvk</i>)	T1	QL (4 EA per 28 days)
SIMLANDI (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.4ML (<i>Adalimumab-ryvk</i>)	T1	QL (4 EA per 28 days)
SIMPONI ARIA (<i>Golimumab</i>)	T1	PA
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>Golimumab</i>)	T1	PA
SYMPROIC (<i>Naldemedine Tosylate</i>)	T1	PA
TRULANCE (<i>Plecanatide</i>)	T1	PA
Guanylate Cyclase C (Gcc) Recept Agonist		
LINZESS (<i>Linaclotide</i>)	T1	PA
TRULANCE (<i>Plecanatide</i>)	T1	PA
Histamine H2-Antagonists		
<i>Cimetidine Oral</i>	T1	
<i>Famotidine Oral Suspension Reconstituted</i>	T1	
<i>Famotidine Oral Tablet 20 MG, 40 MG</i>	T1	
Immunomodulatory Agents (56:44)		
ENTYVIO INTRAVENOUS (<i>Vedolizumab</i>)	T1	PA
Lipotropic Agents		

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>B Complex Formula 1 (Lipotrop)</i>	T1	
<i>B Complex-C Oral Tablet</i>	T1	
<i>Balance B-100</i>	T1	
Neurokinin-1 Receptor Antagonists		
AKYNZEO ORAL (<i>Netupitant-Palonosetron</i>)	T1	PA
<i>Aprepitant Oral Capsule 125 MG, 80 & 125 MG, 80 MG</i>	T1	QL (30 EA per 30 days)
<i>Aprepitant Oral Capsule 40 MG</i>	T1	QL (1 EA per 30 days)
Opioid Antagonists (56:18)		
MOVANTIK (<i>Naloxegol Oxalate</i>)	T1	PA
RELISTOR ORAL (<i>Methylnaltrexone Bromide</i>)	T1	PA
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML (<i>Methylnaltrexone Bromide</i>)	T1	PA
RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>Methylnaltrexone Bromide</i>)	T1	PA
SYMPROIC (<i>Naldemedine Tosylate</i>)	T1	PA
Prokinetic Agents		
<i>Metoclopramide HCl +RFID</i>	T1	
<i>Metoclopramide HCl Injection</i>	T1	
<i>Metoclopramide HCl Oral Solution 10 MG/10ML, 5 MG/5ML</i>	T1	
<i>Metoclopramide HCl Oral Tablet</i>	T1	
Prostaglandins		
<i>miSOPROStol Oral</i>	T1	
Protectants		
<i>Sucralfate Oral</i>	T1	
Proton-Pump Inhibitors		
<i>Amoxicill-Clarithro-Lansopraz Oral Therapy Pack</i>	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Esomeprazole Magnesium Oral Capsule Delayed Release</i>	T1	
<i>Lansoprazole Oral Capsule Delayed Release</i>	T1	
<i>Lansoprazole Oral Tablet Delayed Release Dispersible 15 MG</i>	T1	
<i>Lansoprazole Oral Tablet Delayed Release Dispersible 30 MG</i>	T1	QL (30 EA per 30 days); AL (Max 9 Years)
<i>Omeprazole Oral Capsule Delayed Release 10 MG, 20 MG</i>	T1	
<i>Omeprazole Oral Capsule Delayed Release 40 MG</i>	T1	QL (60 EA per 30 days)
<i>Omeprazole-Sodium Bicarbonate Oral Capsule 20-1100 MG</i>	T1	
<i>Pantoprazole Sodium Intravenous</i>	T1	PA
<i>Pantoprazole Sodium Oral Tablet Delayed Release</i>	T1	
<i>RABEprazole Sodium Oral Tablet Delayed Release</i>	T1	
Heavy Metal Antagonists		
Heavy Metal Antagonists		
<i>CHEMET (Succimer)</i>	T1	
<i>Deferasirox</i>	T1	PA
<i>Deferasirox Granules</i>	T1	PA
<i>Deferiprone</i>	T1	PA
<i>Deferoxamine Mesylate</i>	T1	PA
FERRIPROX ORAL SOLUTION (<i>Deferiprone</i>)	T1	PA
FERRIPROX TWICE-A-DAY (<i>Deferiprone</i>)	T1	PA
<i>GALZIN (Zinc Acetate (Oral))</i>	T1	PA
<i>penicillAMINE Oral</i>	T1	PA
<i>Pentetate Calcium Trisodium</i>	T1	
<i>Pentetate Zinc Trisodium</i>	T1	
<i>Trientine HCl Oral Capsule 250 MG</i>	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Hormones And Synthetic Substitutes		
Adrenals		
<i>Ala-Cort External Cream 1 %</i>	T1	
<i>Anucort-HC</i>	T1	
ANUSOL-HC EXTERNAL (<i>Hydrocortisone</i>)	T1	
ASMANEX (120 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 220 MCG/ACT (<i>Mometasone Furoate</i>)	T1	
ASMANEX (14 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 220 MCG/ACT (<i>Mometasone Furoate</i>)	T1	
ASMANEX (30 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 110 MCG/ACT, 220 MCG/ACT (<i>Mometasone Furoate</i>)	T1	
ASMANEX (60 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 220 MCG/ACT (<i>Mometasone Furoate</i>)	T1	
ASMANEX HFA (<i>Mometasone Furoate</i>)	T1	
<i>Betamethasone Dipropionate Aug External Cream</i>	T1	
<i>Betamethasone Dipropionate Aug External Gel</i>	T1	
<i>Betamethasone Dipropionate Aug External Lotion</i>	T1	PA
<i>Betamethasone Dipropionate Aug External Ointment</i>	T1	PA
<i>Betamethasone Dipropionate External</i>	T1	
<i>Betamethasone Valerate External Cream</i>	T1	
<i>Betamethasone Valerate External Foam</i>	T1	PA
<i>Betamethasone Valerate External Lotion</i>	T1	
<i>Betamethasone Valerate External Ointment</i>	T1	
BREZTRI AEROSPHERE (<i>Budeson-Glycopyrrol-Formoterol</i>)	T1	PA
<i>Budesonide ER Oral Tablet Extended Release 24 Hour</i>	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Budesonide Inhalation Suspension 0.25 MG/2ML, 0.5 MG/2ML</i>	T1	QL (120 ML per 30 days)
<i>Budesonide Inhalation Suspension 1 MG/2ML</i>	T1	QL (60 ML per 30 days)
<i>Budesonide Oral</i>	T1	QL (90 EA per 30 days)
<i>Budesonide-Formoterol Fumarate</i>	T1	QL (20.4 GM per 30 days)
CORTANE-B EXTERNAL (<i>HC-Pramoxine-Chloroxylenol</i>)	T1	
CORTIFOAM EXTERNAL (<i>Hydrocortisone Acetate</i>)	T1	PA
DEXAMETHASONE INTENSOL (<i>Dexamethasone</i>)	T1	
<i>Dexamethasone Oral Elixir</i>	T1	
<i>Dexamethasone Oral Solution</i>	T1	
<i>Dexamethasone Oral Tablet</i>	T1	
<i>Dexamethasone Oral Tablet Therapy Pack 1.5 MG (51)</i>	T1	
DULERA (<i>Mometasone Furo-Formoterol Fum</i>)	T1	
<i>Fludrocortisone Acetate Oral</i>	T1	
<i>Flunisolide Nasal Solution 25 MCG/ACT (0.025%)</i>	T1	PA
<i>Fluticasone Furoate Ellipta</i>	T1	
<i>Fluticasone Furoate-Vilanterol Inhalation Aerosol Powder Breath Activated 100-25 MCG/ACT, 200-25 MCG/ACT</i>	T1	
<i>Fluticasone Propionate Diskus</i>	T1	
<i>Fluticasone Propionate External Cream</i>	T1	
<i>Fluticasone Propionate External Ointment</i>	T1	
<i>Fluticasone Propionate HFA</i>	T1	
<i>Fluticasone Propionate Nasal</i>	T1	
<i>Fluticasone-Salmeterol Inhalation Aerosol</i>	T1	PA
<i>Fluticasone-Salmeterol Inhalation Aerosol Powder Breath Activated 100-50 MCG/ACT, 113-14 MCG/ACT, 232-14 MCG/ACT, 250-50 MCG/ACT, 500-50 MCG/ACT, 55-14 MCG/ACT</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Hydrocortisone (Perianal)</i>	T1	
<i>Hydrocortisone Ace-Pramoxine External Cream 1-1 %</i>	T1	
<i>Hydrocortisone Acetate Rectal</i>	T1	
<i>Hydrocortisone Butyrate External Cream</i>	T1	PA
<i>Hydrocortisone Butyrate External Ointment</i>	T1	PA
<i>Hydrocortisone Butyrate External Solution</i>	T1	PA
<i>Hydrocortisone External Cream 1 %, 2.5 %</i>	T1	
<i>Hydrocortisone External Lotion 2.5 %</i>	T1	
<i>Hydrocortisone External Ointment 1 %, 2.5 %</i>	T1	
<i>Hydrocortisone Oral</i>	T1	
<i>Hydrocortisone Rectal Enema</i>	T1	
<i>Hydrocortisone Valerate</i>	T1	PA
<i>Hydrocortisone-Acetic Acid</i>	T1	
<i>Hydrocort-Pramoxine (Perianal)</i>	T1	
MEDROL ORAL TABLET 2 MG (<i>MethylPREDNISolone</i>)	T1	
<i>methylPREDNISolone Oral</i>	T1	
<i>Mometasone Furoate External</i>	T1	
PRED MILD (<i>PrednisoLONE Acetate</i>)	T1	
<i>prednisoLONE Acetate Ophthalmic</i>	T1	
<i>prednisoLONE Oral Solution</i>	T1	
<i>prednisoLONE Oral Tablet</i>	T1	
<i>PrednisoLONE Sodium Phosphate Ophthalmic</i>	T1	
<i>prednisoLONE Sodium Phosphate Oral Solution 15 MG/5ML, 5 MG/5ML</i>	T1	
PREDNISONONE INTENSOL (<i>PredniSONE</i>)	T1	
<i>PredniSONE Oral Solution</i>	T1	
<i>predniSONE Oral Tablet</i>	T1	
<i>predniSONE Oral Tablet Therapy Pack</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROCTOFOAM HC EXTERNAL (<i>Hydrocortisone Ace-Pramoxine</i>)	T1	PA
<i>Hydrocortisone</i> (Procto-Med Hc External)	T1	
<i>Hydrocortisone</i> (Proctosol Hc External)	T1	
<i>Hydrocortisone</i> (Proctozone-Hc External)	T1	
PULMICORT FLEXHALER (<i>Budesonide</i>)	T1	
QVAR REDHALER (<i>Beclomethasone Diprop HFA</i>)	T1	
TEXACORT (<i>Hydrocortisone</i>)	T1	
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT (<i>Fluticasone-Umeclidin-Vilant</i>)	T1	PA
<i>Triamcinolone Acetonide External Aerosol Solution</i>	T1	PA
<i>Triamcinolone Acetonide External Cream</i>	T1	
<i>Triamcinolone Acetonide External Lotion</i>	T1	
<i>Triamcinolone Acetonide External Ointment 0.025 %, 0.1 %, 0.5 %</i>	T1	
<i>Triamcinolone Acetonide External Ointment 0.05 %</i>	T1	PA
<i>Triamcinolone in Absorbase</i>	T1	PA
<i>Triamcinolone Acetonide</i> (Triderm External Cream 0.5 %)	T1	
<i>Fluticasone-Salmeterol</i> (Wixela Inhub Inhalation Aerosol Powder Breath Activated 100-50 Mcg/Act, 250-50 Mcg/Act, 500-50 Mcg/Act)	T1	
Alpha-Glucosidase Inhibitors		
<i>Acarbose Oral</i>	T1	
<i>Miglitol</i>	T1	ST
Androgens		
COVARYX (<i>Est Estrogens-Methyltest</i>)	T1	
COVARYX HS (<i>Est Estrogens-Methyltest</i>)	T1	
<i>Danazol Oral</i>	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EEMT (<i>Est Estrogens-Methyltest</i>)	T1	
EEMT HS (<i>Est Estrogens-Methyltest</i>)	T1	
<i>Est Estrogens-Methyltest DS</i>	T1	
<i>Est Estrogens-Methyltest HS</i>	T1	
<i>Est Estrogens-Methyltest Oral Tablet 1.25-2.5 MG</i>	T1	
<i>methylTESTOSTERone Oral</i>	T1	PA
<i>Testosterone Cypionate Injection Solution 200 MG/ML</i>	T1	QL (4 ML per 28 days)
<i>Testosterone Cypionate Intramuscular Solution 200 MG/ML</i>	T1	QL (4 ML per 28 days)
<i>Testosterone Enanthate Intramuscular Solution</i>	T1	
<i>Testosterone Transdermal Gel 12.5 MG/ACT (1%), 25 MG/2.5GM (1%), 50 MG/5GM (1%)</i>	T1	PA
Antiestrogens		
<i>Anastrozole Oral</i>	T1	QL (30 EA per 30 days)
<i>Exemestane</i>	T1	
<i>Letrozole Oral</i>	T1	QL (30 EA per 30 days)
Antigonadotropins		
<i>Cetrorelix Acetate</i>	T1	PA
ECONTRA ONE-STEP (<i>Levonorgestrel</i>)	T1	
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG (<i>Degarelix Acetate</i>)	T1	QL (1 EA per 30 days)
<i>Ganirelix Acetate Subcutaneous Solution Prefilled Syringe</i>	T1	PA
HER STYLE (<i>Levonorgestrel</i>)	T1	
KYLEENA (<i>Levonorgestrel</i>)	T1	
<i>Levonorgestrel Oral Tablet 1.5 MG</i>	T1	
LILETTA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 20.1 MCG/DAY (<i>Levonorgestrel</i>)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MIRENA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 20 MCG/DAY (<i>Levonorgestrel</i>)	T1	
MY CHOICE (<i>Levonorgestrel</i>)	T1	
MY WAY (<i>Levonorgestrel</i>)	T1	
NEW DAY (<i>Levonorgestrel</i>)	T1	
NEXPLANON (<i>Etonogestrel</i>)	T1	
OPCICON ONE-STEP (<i>Levonorgestrel</i>)	T1	
OPTION 2 (<i>Levonorgestrel</i>)	T1	
ORILISSA (<i>Elagolix Sodium</i>)	T1	PA
SKYLA (<i>Levonorgestrel</i>)	T1	
SLYND (<i>Drospirenone</i>)	T1	
<i>Testosterone Cypionate Injection Solution 200 MG/ML</i>	T1	QL (4 ML per 28 days)
<i>Testosterone Cypionate Intramuscular Solution 200 MG/ML</i>	T1	QL (4 ML per 28 days)
<i>Testosterone Enanthate Intramuscular Solution</i>	T1	
<i>Testosterone Transdermal Gel 12.5 MG/ACT (1%), 25 MG/2.5GM (1%), 50 MG/5GM (1%)</i>	T1	PA
Antihypoglycemic Agents, Miscellaneous		
<i>Diazoxide Oral</i>	T1	PA
Antiparathyroid Agents		
<i>Calcitonin (Salmon) Nasal</i>	T1	
Antithyroid Agents		
<i>Iodine Strong Oral</i>	T1	
<i>methIMazole Oral</i>	T1	
<i>Propylthiouracil Oral</i>	T1	
Biguanides		
<i>Alogliptin-metFORMIN HCl</i>	T1	ST
<i>glipiZIDE-metFORMIN HCl</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>GlyBURIDE-MetFORMIN Oral Tablet 1.25-250 MG</i>	T1	PA
<i>glyBURIDE-metFORMIN Oral Tablet 2.5-500 MG, 5-500 MG</i>	T1	
<i>INVOKAMET (Canagliflozin-Metformin HCl)</i>	T1	QL (60 EA per 30 days)
<i>JANUMET (SITagliptin Phos-metFORMIN HCl)</i>	T1	ST
<i>JANUMET XR (SITagliptin Phos-metFORMIN HCl)</i>	T1	ST
<i>metFORMIN HCl ER</i>	T1	
<i>metFORMIN HCl Oral Tablet 1000 MG, 500 MG, 850 MG</i>	T1	
<i>SYNJARDY (Empagliflozin-Metformin HCl)</i>	T1	QL (60 EA per 30 days)
<i>SYNJARDY XR (Empagliflozin-Metformin HCl)</i>	T1	QL (30 EA per 30 days)
<i>XIGDUO XR (Dapagliflozin Prop-metFORMIN)</i>	T1	QL (30 EA per 30 days)
Contraceptives		
<i>Levonorgestrel-Ethinyl Estrad (Afirmelle)</i>	T1	
<i>Levonorgestrel-Ethinyl Estrad (Altavera)</i>	T1	
<i>Alyacen 1/35</i>	T1	
<i>Alyacen 7/7/7</i>	T1	
<i>ANNOVERA (Segesterone-Ethinyl Estradiol)</i>	T1	
<i>Desogestrel-Ethinyl Estradiol (Apri)</i>	T1	
<i>ARANELLE (Norethin-Eth Estrad Triphasic)</i>	T1	
<i>Levonorgestrel-Ethinyl Estrad (Aubra Eq)</i>	T1	
<i>Norethindrone Acet-Ethinyl Est (Aurovela 1.5/30)</i>	T1	
<i>Norethindrone Acet-Ethinyl Est (Aurovela 1/20)</i>	T1	
<i>Norethin Ace-Eth Estrad-FE (Aurovela Fe 1.5/30)</i>	T1	
<i>Norethin Ace-Eth Estrad-FE (Aurovela Fe 1/20)</i>	T1	
<i>AVERI (Desogestrel-Eth Estrad-FE)</i>	T1	
<i>Levonorgestrel-Ethinyl Estrad (Aviane)</i>	T1	
<i>Levonorgestrel-Ethinyl Estrad (Ayuna)</i>	T1	
<i>Desogestrel-Ethinyl Estradiol (Azurette)</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Norethindrone-Eth Estradiol</i> (Balziva)	T1	
<i>Norethin Ace-Eth Estrad-FE</i> (Blisovi Fe 1.5/30)	T1	
<i>Norethin Ace-Eth Estrad-FE</i> (Blisovi Fe 1/20)	T1	
<i>Briellyn</i>	T1	
<i>Levonorgestrel-Ethinyl Estrad</i> (Chateal Eq)	T1	
<i>Norgestrel-Ethinyl Estradiol</i> (Cryselle-28)	T1	
<i>Desogestrel-Ethinyl Estradiol</i> (Cyred Eq)	T1	
<i>Norethindrone-Eth Estradiol</i> (Dasetta 1/35 (28))	T1	
<i>Norethin-Eth Estrad Triphasic</i> (Dasetta 7/7/7)	T1	
<i>Norethindrone</i> (Deblitane)	T1	
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE (<i>MedroxyPROGESTERone Acetate</i>)	T1	PA
<i>Desogestrel-Ethinyl Estradiol Oral Tablet 0.15-0.02/0.01 MG (21/5)</i>	T1	
<i>Drospiren-Eth Estrad-Levomefol</i>	T1	
<i>Drospirenone-Ethinyl Estradiol</i>	T1	
ECONTRA ONE-STEP (<i>Levonorgestrel</i>)	T1	
<i>Norgestrel-Ethinyl Estradiol</i> (Elinest)	T1	
ELLA (<i>Ulipristal Acetate</i>)	T1	
<i>Etonogestrel-Ethinyl Estradiol</i> (Eluryng)	T1	
<i>Desogestrel-Ethinyl Estradiol</i> (Enskyce Oral Tablet 0.15-30 Mg-Mcg)	T1	
<i>Norgestimate-Eth Estradiol</i> (Estarylla)	T1	
<i>Ethinodiol Diac-Eth Estradiol</i>	T1	
<i>Etonogestrel-Ethinyl Estradiol</i>	T1	
<i>Levonorgestrel-Ethinyl Estrad</i> (Falmina)	T1	
<i>Norethin Ace-Eth Estrad-FE</i> (Feirza 1.5/30)	T1	
<i>Norethin Ace-Eth Estrad-FE</i> (Feirza 1/20)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FEMLYV (<i>Norethindrone Acet-Ethinyl Est</i>)	T1	
<i>Norethin-Eth Estradiol-Fe</i> (Galbriela)	T1	
<i>Norethindrone Acet-Ethinyl Est</i> (Hailey 1.5/30)	T1	
<i>Norethin Ace-Eth Estrad-FE</i> (Hailey Fe 1.5/30)	T1	
<i>Norethin Ace-Eth Estrad-FE</i> (Hailey Fe 1/20)	T1	
<i>Etonogestrel-Ethinyl Estradiol</i> (Haloette)	T1	
<i>Norethindrone</i> (Heather)	T1	
HER STYLE (<i>Levonorgestrel</i>)	T1	
<i>Levonorgest-Eth Estrad 91-Day</i> (Iclevia)	T1	
<i>Norethindrone</i> (Incassia)	T1	
<i>Desogestrel-Ethinyl Estradiol</i> (Isibloom)	T1	
<i>Drospirenone-Ethinyl Estradiol</i> (Jasmiel)	T1	
<i>Levonorgest-Eth Estrad 91-Day</i> (Jolessa)	T1	
<i>Desogestrel-Ethinyl Estradiol</i> (Juleber)	T1	
<i>Norethindrone Acet-Ethinyl Est</i> (Junel 1.5/30)	T1	
<i>Norethindrone Acet-Ethinyl Est</i> (Junel 1/20)	T1	
<i>Norethin Ace-Eth Estrad-FE</i> (Junel Fe 1.5/30)	T1	
<i>Norethin Ace-Eth Estrad-FE</i> (Junel Fe 1/20)	T1	
<i>Desogestrel-Ethinyl Estradiol</i> (Kalliga)	T1	
<i>Desogestrel-Ethinyl Estradiol</i> (Kariva)	T1	
<i>Ethinodiol Diac-Eth Estradiol</i> (Kelnor 1/35)	T1	
KYLEENA (<i>Levonorgestrel</i>)	T1	
<i>Norethindrone Acet-Ethinyl Est</i> (Larin 1.5/30)	T1	
<i>Norethindrone Acet-Ethinyl Est</i> (Larin 1/20)	T1	
<i>Norethin Ace-Eth Estrad-FE</i> (Larin Fe 1.5/30)	T1	
<i>Norethin Ace-Eth Estrad-FE</i> (Larin Fe 1/20)	T1	
<i>Levonorgestrel-Ethinyl Estrad</i> (Lessina)	T1	
<i>Levonorg-Eth Estrad Triphasic</i> (Levonest)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Levonorgest-Eth Est & Eth Est</i>	T1	
<i>Levonorgest-Eth Estrad 91-Day</i>	T1	
<i>Levonorgest-Eth Estradiol-Iron</i>	T1	
<i>Levonorgestrel Oral Tablet 1.5 MG</i>	T1	
<i>Levonorgestrel-Ethinyl Estrad</i>	T1	
<i>Levonorg-Eth Estrad Triphasic Oral Tablet 50-30/75-40/125-30 MCG</i>	T1	
<i>Levonorgestrel-Ethinyl Estrad (Levora 0.15/30 (28))</i>	T1	
LILETTA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 20.1 MCG/DAY (<i>Levonorgestrel</i>)	T1	
LO LOESTRIN FE (<i>Norethin-Eth Estrad-Fe Biphas</i>)	T1	
<i>Drospirenone-Ethinyl Estradiol (Loryna)</i>	T1	
<i>Norgestrel-Ethinyl Estradiol (Low-Ogestrel)</i>	T1	
<i>Drospirenone-Ethinyl Estradiol (Lo-Zumandimine)</i>	T1	
<i>Levonorgestrel-Ethinyl Estrad (Lutera)</i>	T1	
<i>Norethindrone (Lyleq)</i>	T1	
<i>Norethindrone (Lyza)</i>	T1	
<i>Marlissa</i>	T1	
<i>medroxyPROGESTERone Acetate Intramuscular</i>	T1	
<i>Norethindrone Acet-Ethinyl Est (Microgestin 1.5/30)</i>	T1	
<i>Norethindrone Acet-Ethinyl Est (Microgestin 1/20)</i>	T1	
<i>Norethin Ace-Eth Estrad-FE (Microgestin Fe 1.5/30)</i>	T1	
<i>Norethin Ace-Eth Estrad-FE (Microgestin Fe 1/20)</i>	T1	
<i>Norgestimate-Eth Estradiol (Mili)</i>	T1	
MIRENA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 20 MCG/DAY (<i>Levonorgestrel</i>)	T1	
<i>Norgestimate-Eth Estradiol (Mono-Linyah)</i>	T1	
MY CHOICE (<i>Levonorgestrel</i>)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MY WAY (<i>Levonorgestrel</i>)	T1	
NATAZIA (<i>Estradiol Valerate-Dienogest</i>)	T1	
Norethindrone-Eth Estradiol (Necon 0.5/35 (28))	T1	
NEW DAY (<i>Levonorgestrel</i>)	T1	
NEXPLANON (<i>Etonogestrel</i>)	T1	
NEXTSTELLIS (<i>Drospirenone-Estetrol</i>)	T1	
Drospirenone-Ethinyl Estradiol (Nikki)	T1	
Norethindrone (Nora-Be)	T1	
Norelgestromin-Eth Estradiol	T1	
Norethin Ace-Eth Estrad-FE Oral Capsule	T1	
Norethin Ace-Eth Estrad-FE Oral Tablet 1.5-30 MG-MCG	T1	
Norethin Ace-Eth Estrad-FE Oral Tablet Chewable	T1	
Norethindrone Acet-Ethinyl Est Oral Tablet	T1	
Norethindrone Oral	T1	
Norethin-Eth Estradiol-Fe Oral Tablet Chewable 0.4-35 MG-MCG	T1	
Norgestimate-Eth Estradiol Oral Tablet 0.25-35 MG-MCG	T1	
Norgestim-Eth Estrad Triphasic	T1	
Norethindrone (Norlyda)	T1	
Norethindrone-Eth Estradiol (Nortrel 0.5/35 (28))	T1	
Norethindrone-Eth Estradiol (Nortrel 1/35 (21))	T1	
Norethindrone-Eth Estradiol (Nortrel 1/35 (28))	T1	
Norethin-Eth Estrad Triphasic (Nortrel 7/7/7)	T1	
Norethindrone-Eth Estradiol (Nylia 1/35)	T1	
Norethin-Eth Estrad Triphasic (Nylia 7/7/7)	T1	
OPCICON ONE-STEP (<i>Levonorgestrel</i>)	T1	
OPILL (<i>Norgestrel</i>)	T1	
OPTION 2 (<i>Levonorgestrel</i>)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Levonorgestrel-Ethinyl Estrad (Orsythia)	T1	
Norethindrone-Eth Estradiol (Phillith)	T1	
Desogestrel-Ethinyl Estradiol (Pimtreea)	T1	
Norethin-Eth Estrad Triphasic (Pirmella 7/7/7)	T1	
Levonorgestrel-Ethinyl Estrad (Portia-28)	T1	
Desogestrel-Ethinyl Estradiol (Reclipsen)	T1	
Levonorgest-Eth Estrad 91-Day (Rosyrah)	T1	
Levonorgest-Eth Estrad 91-Day (Setlakin)	T1	
Norethindrone (Sharobel)	T1	
Desogestrel-Ethinyl Estradiol (Simliya)	T1	
SKYLA (Levonorgestrel)	T1	
SLYND (Drospirenone)	T1	
Norgestimate-Eth Estradiol (Sprintec 28)	T1	
Levonorgestrel-Ethinyl Estrad (Sronyx)	T1	
Drospirenone-Ethinyl Estradiol (Syeda)	T1	
Norethin Ace-Eth Estrad-FE (Tarina Fe 1/20 Eq)	T1	
Norethindron-Ethinyl Estrad-Fe (Tilia Fe)	T1	
Norgestim-Eth Estrad Triphasic (Tri Femynor)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Estarylla)	T1	
Norethindron-Ethinyl Estrad-Fe (Tri-Legest Fe)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Linyah)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Lo-Estarylla)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Lo-Marzia)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Lo-Mili)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Lo-Sprintec)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Mili)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Sprintec)	T1	
Levonorg-Eth Estrad Triphasic (Trivora (28))	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Norgestim-Eth Estrad Triphasic</i> (Tri-Vylibra)	T1	
<i>Norgestim-Eth Estrad Triphasic</i> (Tri-Vylibra Lo)	T1	
TWIRLA (<i>Levonorgestrel-Eth Estradiol</i>)	T1	
TYBLUME ORAL TABLET CHEWABLE (<i>Levonorgestrel-Ethinyl Estrad</i>)	T1	
<i>Ethinodiol Diac-Eth Estradiol</i> (Valtya 1/50)	T1	
VELIVET (<i>Desogestrel-Ethinyl Estradiol</i>)	T1	
<i>Drospirenone-Ethinyl Estradiol</i> (Vestura)	T1	
<i>Levonorgestrel-Ethinyl Estrad</i> (Vienna)	T1	
<i>Viorele</i>	T1	
<i>Desogestrel-Ethinyl Estradiol</i> (Volnea)	T1	
<i>Norgestimate-Eth Estradiol</i> (Vylibra)	T1	
<i>Norethindrone-Eth Estradiol</i> (Wera)	T1	
<i>Norethin-Eth Estradiol-Fe</i> (Xelria Fe)	T1	
<i>Ethinodiol Diac-Eth Estradiol</i> (Zovia 1/35 (28))	T1	
<i>Drospirenone-Ethinyl Estradiol</i> (Zumandimine)	T1	
Dipeptidyl Peptidase-4(Dpp-4) Inhibitors		
<i>Alogliptin Benzoate</i>	T1	ST
<i>Alogliptin-metFORMIN HCl</i>	T1	ST
<i>Alogliptin-Pioglitazone Oral Tablet 12.5-30 MG, 25-15 MG, 25-30 MG, 25-45 MG</i>	T1	ST
JANUMET (<i>SITagliptin Phos-metFORMIN HCl</i>)	T1	ST
JANUMET XR (<i>SITagliptin Phos-metFORMIN HCl</i>)	T1	ST
JANUVIA (<i>SitaGLIPTin Phosphate</i>)	T1	ST
Estrogen Agonist-Antagonists		
<i>clomiPHENE Citrate Oral</i>	T1	PA
<i>Raloxifene HCl</i>	T1	
<i>Tamoxifen Citrate Oral</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Toremifene Citrate</i>	T1	
Estrogens		
<i>Levonorgestrel-Ethinyl Estrad (Afirmelle)</i>	T1	
<i>Levonorgestrel-Ethinyl Estrad (Altavera)</i>	T1	
<i>Alyacen 1/35</i>	T1	
<i>Alyacen 7/7/7</i>	T1	
ANNOVERA (<i>Segesterone-Ethinyl Estradiol</i>)	T1	
<i>Desogestrel-Ethinyl Estradiol (Apri)</i>	T1	
ARANELLE (<i>Norethin-Eth Estrad Triphasic</i>)	T1	
<i>Levonorgestrel-Ethinyl Estrad (Aubra Eq)</i>	T1	
<i>Norethindrone Acet-Ethinyl Est (Aurovela 1.5/30)</i>	T1	
<i>Norethindrone Acet-Ethinyl Est (Aurovela 1/20)</i>	T1	
<i>Norethin Ace-Eth Estrad-FE (Aurovela Fe 1.5/30)</i>	T1	
<i>Norethin Ace-Eth Estrad-FE (Aurovela Fe 1/20)</i>	T1	
AVERI (<i>Desogestrel-Eth Estrad-FE</i>)	T1	
<i>Levonorgestrel-Ethinyl Estrad (Aviane)</i>	T1	
<i>Levonorgestrel-Ethinyl Estrad (Ayuna)</i>	T1	
<i>Desogestrel-Ethinyl Estradiol (Azurette)</i>	T1	
<i>Norethindrone-Eth Estradiol (Balziva)</i>	T1	
<i>Norethin Ace-Eth Estrad-FE (Blisovi Fe 1.5/30)</i>	T1	
<i>Norethin Ace-Eth Estrad-FE (Blisovi Fe 1/20)</i>	T1	
<i>Briellyn</i>	T1	
<i>Levonorgestrel-Ethinyl Estrad (Chateal Eq)</i>	T1	
CLIMARA PRO (<i>Estradiol-Levonorgestrel</i>)	T1	PA
COMBIPATCH (<i>Estradiol-Norethindrone Acet</i>)	T1	ST
COVARYX (<i>Est Estrogens-Methyltest</i>)	T1	
COVARYX HS (<i>Est Estrogens-Methyltest</i>)	T1	
<i>Norgestrel-Ethinyl Estradiol (Cryselle-28)</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Desogestrel-Ethinyl Estradiol</i> (Cyred Eq)	T1	
<i>Norethindrone-Eth Estradiol</i> (Dasetta 1/35 (28))	T1	
<i>Norethin-Eth Estrad Triphasic</i> (Dasetta 7/7/7)	T1	
DEPO-ESTRADIOL (<i>Estradiol Cypionate</i>)	T1	PA
<i>Desogestrel-Ethinyl Estradiol Oral Tablet 0.15-0.02/0.01 MG (21/5)</i>	T1	
<i>Estradiol</i> (Dotti)	T1	QL (8 EA per 28 days)
<i>Drospiren-Eth Estrad-Levomefol</i>	T1	
<i>Drospirenone-Ethinyl Estradiol</i>	T1	
EEMT (<i>Est Estrogens-Methyltest</i>)	T1	
EEMT HS (<i>Est Estrogens-Methyltest</i>)	T1	
<i>Norgestrel-Ethinyl Estradiol</i> (Elinest)	T1	
<i>Etonogestrel-Ethinyl Estradiol</i> (Eluryng)	T1	
<i>Desogestrel-Ethinyl Estradiol</i> (Enskyce Oral Tablet 0.15-30 Mg-Mcg)	T1	
<i>Est Estrogens-Methyltest DS</i>	T1	
<i>Est Estrogens-Methyltest HS</i>	T1	
<i>Est Estrogens-Methyltest Oral Tablet 1.25-2.5 MG</i>	T1	
<i>Norgestimate-Eth Estradiol</i> (Estarylla)	T1	
<i>Estradiol Oral</i>	T1	
<i>Estradiol Transdermal Gel 0.75 MG/1.25 GM (0.06%)</i>	T1	
<i>Estradiol Transdermal Patch Twice Weekly</i>	T1	QL (8 EA per 28 days)
<i>Estradiol Transdermal Patch Weekly</i>	T1	
<i>Estradiol Vaginal Cream 0.01 %</i>	T1	
<i>Estradiol Vaginal Tablet</i>	T1	
<i>Estradiol Valerate Intramuscular</i>	T1	PA
<i>Estradiol-Norethindrone Acet Oral Tablet 1-0.5 MG</i>	T1	PA
<i>Ethinodiol Diac-Eth Estradiol</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Etonogestrel-Ethinyl Estradiol</i>	T1	
<i>Levonorgestrel-Ethinyl Estrad</i> (Falmina)	T1	
<i>Norethin Ace-Eth Estrad-FE</i> (Feirza 1.5/30)	T1	
<i>Norethin Ace-Eth Estrad-FE</i> (Feirza 1/20)	T1	
<i>FEMLYV (Norethindrone Acet-Ethinyl Est)</i>	T1	
<i>FEMRING (Estradiol Acetate)</i>	T1	PA
<i>Norethindrone-Eth Estradiol</i> (Fyavolv Oral Tablet 1-5 Mg-Mcg)	T1	PA
<i>Norethin-Eth Estradiol-Fe</i> (Galbriela)	T1	
<i>Norethindrone Acet-Ethinyl Est</i> (Hailey 1.5/30)	T1	
<i>Norethin Ace-Eth Estrad-FE</i> (Hailey Fe 1.5/30)	T1	
<i>Norethin Ace-Eth Estrad-FE</i> (Hailey Fe 1/20)	T1	
<i>Etonogestrel-Ethinyl Estradiol</i> (Haloette)	T1	
<i>Levonorgest-Eth Estrad 91-Day</i> (Iclevia)	T1	
<i>Desogestrel-Ethinyl Estradiol</i> (Isibloom)	T1	
<i>Drospirenone-Ethinyl Estradiol</i> (Jasmiel)	T1	
<i>Norethindrone-Eth Estradiol</i> (Jinteli)	T1	PA
<i>Levonorgest-Eth Estrad 91-Day</i> (Jolessa)	T1	
<i>Desogestrel-Ethinyl Estradiol</i> (Juleber)	T1	
<i>Norethindrone Acet-Ethinyl Est</i> (Junel 1.5/30)	T1	
<i>Norethindrone Acet-Ethinyl Est</i> (Junel 1/20)	T1	
<i>Norethin Ace-Eth Estrad-FE</i> (Junel Fe 1.5/30)	T1	
<i>Norethin Ace-Eth Estrad-FE</i> (Junel Fe 1/20)	T1	
<i>Desogestrel-Ethinyl Estradiol</i> (Kalliga)	T1	
<i>Desogestrel-Ethinyl Estradiol</i> (Kariva)	T1	
<i>Ethinodiol Diac-Eth Estradiol</i> (Kelnor 1/35)	T1	
<i>Norethindrone Acet-Ethinyl Est</i> (Larin 1.5/30)	T1	
<i>Norethindrone Acet-Ethinyl Est</i> (Larin 1/20)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Norethin Ace-Eth Estrad-FE</i> (Larin Fe 1.5/30)	T1	
<i>Norethin Ace-Eth Estrad-FE</i> (Larin Fe 1/20)	T1	
<i>Levonorgestrel-Ethinyl Estrad</i> (Lessina)	T1	
<i>Levonorg-Eth Estrad Triphasic</i> (Levonest)	T1	
<i>Levonorgest-Eth Est & Eth Est</i>	T1	
<i>Levonorgest-Eth Estrad 91-Day</i>	T1	
<i>Levonorgest-Eth Estradiol-Iron</i>	T1	
<i>Levonorgestrel-Ethinyl Estrad</i>	T1	
<i>Levonorg-Eth Estrad Triphasic Oral Tablet 50-30/75-40/125-30 MCG</i>	T1	
<i>Levonorgestrel-Ethinyl Estrad</i> (Levora 0.15/30 (28))	T1	
<i>LO LOESTRIN FE (Norethin-Eth Estrad-Fe Biphas)</i>	T1	
<i>Drospirenone-Ethinyl Estradiol</i> (Loryna)	T1	
<i>Norgestrel-Ethinyl Estradiol</i> (Low-Ogestrel)	T1	
<i>Drospirenone-Ethinyl Estradiol</i> (Lo-Zumandimine)	T1	
<i>Levonorgestrel-Ethinyl Estrad</i> (Lutera)	T1	
<i>Estradiol</i> (Lyllana)	T1	QL (8 EA per 28 days)
<i>Marlissa</i>	T1	
<i>Norethindrone Acet-Ethinyl Est</i> (Microgestin 1.5/30)	T1	
<i>Norethindrone Acet-Ethinyl Est</i> (Microgestin 1/20)	T1	
<i>Norethin Ace-Eth Estrad-FE</i> (Microgestin Fe 1.5/30)	T1	
<i>Norethin Ace-Eth Estrad-FE</i> (Microgestin Fe 1/20)	T1	
<i>Norgestimate-Eth Estradiol</i> (Mili)	T1	
<i>Estradiol-Norethindrone Acet</i> (Mimvey)	T1	PA
<i>Norgestimate-Eth Estradiol</i> (Mono-Linyah)	T1	
<i>NATAZIA (Estradiol Valerate-Dienogest)</i>	T1	
<i>Norethindrone-Eth Estradiol</i> (Necon 0.5/35 (28))	T1	
<i>NEXTSTELLIS (Drospirenone-Estetrol)</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Drospirenone-Ethinyl Estradiol</i> (Nikki)	T1	
<i>Norelgestromin-Eth Estradiol</i>	T1	
<i>Norethin Ace-Eth Estrad-FE Oral Capsule</i>	T1	
<i>Norethin Ace-Eth Estrad-FE Oral Tablet 1.5-30 MG-MCG</i>	T1	
<i>Norethin Ace-Eth Estrad-FE Oral Tablet Chewable</i>	T1	
<i>Norethindrone Acet-Ethinyl Est Oral Tablet</i>	T1	
<i>Norethindrone-Eth Estradiol Oral Tablet 1-5 MG-MCG</i>	T1	PA
<i>Norethin-Eth Estradiol-Fe Oral Tablet Chewable 0.4-35 MG-MCG</i>	T1	
<i>Norgestimate-Eth Estradiol Oral Tablet 0.25-35 MG-MCG</i>	T1	
<i>Norgestim-Eth Estrad Triphasic</i>	T1	
<i>Norethindrone-Eth Estradiol</i> (Nortrel 0.5/35 (28))	T1	
<i>Norethindrone-Eth Estradiol</i> (Nortrel 1/35 (21))	T1	
<i>Norethindrone-Eth Estradiol</i> (Nortrel 1/35 (28))	T1	
<i>Norethin-Eth Estrad Triphasic</i> (Nortrel 7/7/7)	T1	
<i>Norethindrone-Eth Estradiol</i> (Nylia 1/35)	T1	
<i>Norethin-Eth Estrad Triphasic</i> (Nylia 7/7/7)	T1	
<i>Levonorgestrel-Ethinyl Estrad</i> (Orsythia)	T1	
<i>Norethindrone-Eth Estradiol</i> (Philith)	T1	
<i>Desogestrel-Ethinyl Estradiol</i> (Pimtreea)	T1	
<i>Norethin-Eth Estrad Triphasic</i> (Pirmella 7/7/7)	T1	
<i>Levonorgestrel-Ethinyl Estrad</i> (Portia-28)	T1	
PREMARIN ORAL (<i>Estrogens Conjugated</i>)	T1	
PREMARIN VAGINAL (<i>Estrogens, Conjugated</i>)	T1	
PREMPHASE (<i>Conj Estrog-Medroxyprogest Ace</i>)	T1	
PREMPRO (<i>Conj Estrog-Medroxyprogest Ace</i>)	T1	
<i>Desogestrel-Ethinyl Estradiol</i> (Reclipsen)	T1	
<i>Levonorgest-Eth Estrad 91-Day</i> (Rosyrah)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Levonorgest-Eth Estrad 91-Day (Setlakin)	T1	
Desogestrel-Ethinyl Estradiol (Simliya)	T1	
Norgestimate-Eth Estradiol (Sprintec 28)	T1	
Levonorgestrel-Ethinyl Estrad (Sronyx)	T1	
Drospirenone-Ethinyl Estradiol (Syeda)	T1	
Norethin Ace-Eth Estrad-FE (Tarina Fe 1/20 Eq)	T1	
Norethindron-Ethinyl Estrad-Fe (Tilia Fe)	T1	
Norgestim-Eth Estrad Triphasic (Tri Femynor)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Estarylla)	T1	
Norethindron-Ethinyl Estrad-Fe (Tri-Legest Fe)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Linyah)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Lo-Estarylla)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Lo-Marzia)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Lo-Mili)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Lo-Sprintec)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Mili)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Sprintec)	T1	
Levonorg-Eth Estrad Triphasic (Trivora (28))	T1	
Norgestim-Eth Estrad Triphasic (Tri-Vylibra)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Vylibra Lo)	T1	
TWIRLA (Levonorgestrel-Eth Estradiol)	T1	
TYBLUME ORAL TABLET CHEWABLE (Levonorgestrel-Ethinyl Estrad)	T1	
Ethinodiol Diac-Eth Estradiol (Valtya 1/50)	T1	
VELIVET (Desogestrel-Ethinyl Estradiol)	T1	
Drospirenone-Ethinyl Estradiol (Vestura)	T1	
Levonorgestrel-Ethinyl Estrad (Vienna)	T1	
Viorele	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Desogestrel-Ethinyl Estradiol</i> (Volnea)	T1	
<i>Norgestimate-Eth Estradiol</i> (Vylibra)	T1	
<i>Norethindrone-Eth Estradiol</i> (Wera)	T1	
<i>Norethin-Eth Estradiol-Fe</i> (Xelria Fe)	T1	
<i>Estradiol</i> (Yuvafem)	T1	
<i>Ethinodiol Diac-Eth Estradiol</i> (Zovia 1/35 (28))	T1	
<i>Drospirenone-Ethinyl Estradiol</i> (Zumandimine)	T1	
Glycogenolytic Agents		
BAQSIMI ONE PACK (<i>Glucagon</i>)	T1	
BAQSIMI TWO PACK (<i>Glucagon</i>)	T1	
<i>Glucagon Emergency Injection Solution Reconstituted</i>	T1	
Gonadotropins		
<i>Chorionic Gonadotropin Intramuscular</i>	T1	PA
ELIGARD (<i>Leuprolide Acetate (3 Month)</i>)	T1	
FOLLISTIM AQ SUBCUTANEOUS (<i>Follitropin Beta</i>)	T1	PA
GONAL-F INJECTION SOLUTION RECONSTITUTED 450 UNIT (<i>Follitropin Alfa</i>)	T1	PA
GONAL-F RFF REDIJECT SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNT/0.48ML, 450 UNT/0.72ML, 900 UNT/1.44ML (<i>Follitropin Alfa</i>)	T1	PA
LUPRON DEPOT (1-MONTH) (<i>Leuprolide Acetate</i>)	T1	PA
LUPRON DEPOT (3-MONTH) (<i>Leuprolide Acetate (3 Month)</i>)	T1	PA
LUPRON DEPOT (4-MONTH) (<i>Leuprolide Acetate (4 Month)</i>)	T1	PA
LUPRON DEPOT-PED (1-MONTH) (<i>Leuprolide Acetate</i>)	T1	PA
LUPRON DEPOT-PED (3-MONTH) INTRAMUSCULAR KIT 11.25 MG (<i>Leuprolide Acetate (3 Month)</i>)	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LUPRON DEPOT-PED (6-MONTH) (<i>Leuprolide Acetate (6 Month)</i>)	T1	PA
MENOPUR (<i>Menotropins</i>)	T1	PA
NOVAREL INTRAMUSCULAR SOLUTION RECONSTITUTED 5000 UNIT (<i>Chorionic Gonadotropin</i>)	T1	PA
OVIDREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>Choriogonadotropin Alfa</i>)	T1	PA
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 11.25 MG (<i>Triptorelin Pamoate</i>)	T1	QL (1 EA per 30 days)
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 3.75 MG (<i>Triptorelin Pamoate</i>)	T1	
ZOLADEX (<i>Goserelin Acetate</i>)	T1	
Gonadotropins And Antigonadotropins		
<i>Chorionic Gonadotropin Intramuscular</i>	T1	PA
ELIGARD (<i>Leuprolide Acetate (3 Month)</i>)	T1	
FOLLISTIM AQ SUBCUTANEOUS (<i>Follitropin Beta</i>)	T1	PA
GONAL-F INJECTION SOLUTION RECONSTITUTED 450 UNIT (<i>Follitropin Alfa</i>)	T1	PA
LUPRON DEPOT (1-MONTH) (<i>Leuprolide Acetate</i>)	T1	PA
LUPRON DEPOT (3-MONTH) (<i>Leuprolide Acetate (3 Month)</i>)	T1	PA
LUPRON DEPOT (4-MONTH) (<i>Leuprolide Acetate (4 Month)</i>)	T1	PA
LUPRON DEPOT-PED (1-MONTH) (<i>Leuprolide Acetate</i>)	T1	PA
LUPRON DEPOT-PED (3-MONTH) INTRAMUSCULAR KIT 11.25 MG (<i>Leuprolide Acetate (3 Month)</i>)	T1	PA
MENOPUR (<i>Menotropins</i>)	T1	PA
NOVAREL INTRAMUSCULAR SOLUTION RECONSTITUTED 5000 UNIT (<i>Chorionic Gonadotropin</i>)	T1	PA
ZOLADEX (<i>Goserelin Acetate</i>)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Incretin Mimetics		
MOUNJARO SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>Tirzepatide</i>)	T1	PA
OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/3ML (<i>Semaglutide</i>)	T1	ST; QL (3 ML per 28 days)
OZEMPIC (1 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 4 MG/3ML (<i>Semaglutide</i>)	T1	ST; QL (3 ML per 28 days)
OZEMPIC (2 MG/DOSE) (<i>Semaglutide</i>)	T1	ST; QL (3 ML per 28 days)
RYBELSUS (<i>Semaglutide</i>)	T1	ST; QL (30 EA per 30 days)
TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>Dulaglutide</i>)	T1	ST; QL (2 ML per 28 days)
VICTOZA SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>Liraglutide</i>)	T1	ST; QL (9 ML per 28 days)
Insulins		
APIDRA (<i>Insulin Glulisine</i>)	T1	QL (30 ML per 30 days)
APIDRA SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>Insulin Glulisine</i>)	T1	QL (30 ML per 30 days)
HUMALOG MIX 50/50 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (<i>Insulin Lispro Prot & Lispro</i>)	T1	QL (20 ML per 30 days)
HUMALOG MIX 75/25 (<i>Insulin Lispro Prot & Lispro</i>)	T1	QL (30 ML per 30 days)
HUMALOG SUBCUTANEOUS SOLUTION CARTRIDGE (<i>Insulin Lispro</i>)	T1	QL (30 ML per 30 days)
HUMULIN 70/30 (<i>Insulin NPH Isophane & Regular</i>)	T1	QL (20 ML per 30 days)
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (<i>Insulin NPH Isophane & Regular</i>)	T1	QL (20 ML per 30 days)
HUMULIN N (<i>Insulin NPH Human (Isophane)</i>)	T1	QL (20 ML per 30 days)
HUMULIN N KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (<i>Insulin NPH Human (Isophane)</i>)	T1	QL (20 ML per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HUMULIN R (<i>Insulin Regular Human</i>)	T1	QL (20 ML per 30 days)
HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>Insulin Regular Human</i>)	T1	QL (12 ML per 30 days)
<i>Insulin Asp Prot & Asp FlexPen</i>	T1	QL (30 ML per 30 days)
<i>Insulin Aspart FlexPen</i>	T1	QL (30 ML per 30 days)
<i>Insulin Aspart PenFill</i>	T1	QL (20 ML per 30 days)
<i>Insulin Aspart Prot & Aspart</i>	T1	QL (30 ML per 30 days)
<i>Insulin Lispro (1 Unit Dial)</i>	T1	QL (30 ML per 30 days)
<i>Insulin Lispro Prot & Lispro</i>	T1	QL (30 ML per 30 days)
LANTUS (<i>Insulin Glargine</i>)	T1	QL (30 ML per 30 days)
LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>Insulin Glargine</i>)	T1	QL (30 ML per 30 days)
NOVOLIN 70/30 (<i>Insulin NPH Isophane & Regular</i>)	T1	QL (20 ML per 30 days)
NOVOLIN 70/30 FLEXPEN (<i>Insulin NPH Isophane & Regular</i>)	T1	QL (20 ML per 30 days)
NOVOLIN N (<i>Insulin NPH Human (Isophane)</i>)	T1	QL (20 ML per 30 days)
NOVOLIN N FLEXPEN (<i>Insulin NPH Human (Isophane)</i>)	T1	QL (20 ML per 30 days)
NOVOLIN R (<i>Insulin Regular Human</i>)	T1	QL (120 ML per 30 days)
NOVOLIN R FLEXPEN (<i>Insulin Regular Human</i>)	T1	QL (20 ML per 30 days)
NOVOLIN R RELION (<i>Insulin Regular Human</i>)	T1	QL (20 ML per 30 days)
Intermediate-Acting Insulins		
HUMALOG MIX 50/50 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (<i>Insulin Lispro Prot & Lispro</i>)	T1	QL (20 ML per 30 days)
HUMALOG MIX 75/25 (<i>Insulin Lispro Prot & Lispro</i>)	T1	QL (30 ML per 30 days)
HUMULIN 70/30 (<i>Insulin NPH Isophane & Regular</i>)	T1	QL (20 ML per 30 days)
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (<i>Insulin NPH Isophane & Regular</i>)	T1	QL (20 ML per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HUMULIN N (<i>Insulin NPH Human (Isophane)</i>)	T1	QL (20 ML per 30 days)
HUMULIN N KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (<i>Insulin NPH Human (Isophane)</i>)	T1	QL (20 ML per 30 days)
<i>Insulin Asp Prot & Asp FlexPen</i>	T1	QL (30 ML per 30 days)
<i>Insulin Aspart Prot & Aspart</i>	T1	QL (30 ML per 30 days)
<i>Insulin Lispro Prot & Lispro</i>	T1	QL (30 ML per 30 days)
NOVOLIN 70/30 (<i>Insulin NPH Isophane & Regular</i>)	T1	QL (20 ML per 30 days)
NOVOLIN 70/30 FLEXPEN (<i>Insulin NPH Isophane & Regular</i>)	T1	QL (20 ML per 30 days)
NOVOLIN N (<i>Insulin NPH Human (Isophane)</i>)	T1	QL (20 ML per 30 days)
NOVOLIN N FLEXPEN (<i>Insulin NPH Human (Isophane)</i>)	T1	QL (20 ML per 30 days)
Long-Acting Insulins		
<i>Insulin Glargine-yfgn</i>	T1	QL (30 ML per 30 days)
LANTUS (<i>Insulin Glargine</i>)	T1	QL (30 ML per 30 days)
LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>Insulin Glargine</i>)	T1	QL (30 ML per 30 days)
REZVOGLAR KWIKPEN (<i>Insulin Glargine-aglr</i>)	T1	QL (30 ML per 30 days)
Meglitinides		
<i>Nateglinide</i>	T1	PA
<i>Repaglinide</i>	T1	PA
Parathyroid Agents		
<i>Teriparatide Subcutaneous Solution Pen-Injector 560 MCG/2.24ML</i>	T1	PA
Parathyroid And Antiparathyroid Agents		
<i>Calcitonin (Salmon) Nasal</i>	T1	
Pituitary		
CORTROPHIN (<i>Corticotropin</i>)	T1	PA
CORTROPHIN GEL (<i>Corticotropin</i>)	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Desmopressin Ace Spray Refrig</i>	T1	PA
<i>Desmopressin Acetate Injection</i>	T1	PA
<i>Desmopressin Acetate Nasal</i>	T1	PA
<i>Desmopressin Acetate Oral</i>	T1	
<i>Desmopressin Acetate PF</i>	T1	PA
<i>Desmopressin Acetate Spray</i>	T1	PA
GENOTROPIN MINIQUICK SUBCUTANEOUS PREFILLED SYRINGE (<i>Somatropin</i>)	T1	PA
GENOTROPIN SUBCUTANEOUS CARTRIDGE (<i>Somatropin</i>)	T1	PA
HUMATROPE INJECTION CARTRIDGE (<i>Somatropin</i>)	T1	PA
NORDITROPIN FLEXPPO SUBCUTANEOUS SOLUTION PEN-INJECTOR 15 MG/1.5ML, 5 MG/1.5ML (<i>Somatropin</i>)	T1	PA
NUTROPIN AQ NUSPIN 10 SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>Somatropin</i>)	T1	PA
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 5 MG/1.5ML (<i>Somatropin</i>)	T1	PA
SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG (<i>Somatropin (Non-Refrigerated)</i>)	T1	PA
ZOMACTON (<i>Somatropin</i>)	T1	PA
Progestins		
<i>Levonorgestrel-Ethinyl Estrad</i> (Afirmelle)	T1	
<i>Levonorgestrel-Ethinyl Estrad</i> (Altavera)	T1	
<i>Alyacen 1/35</i>	T1	
<i>Alyacen 7/7/7</i>	T1	
ANNOVERA (<i>Segesterone-Ethinyl Estradiol</i>)	T1	
<i>Desogestrel-Ethinyl Estradiol</i> (Apri)	T1	
ARANELLE (<i>Norethin-Eth Estrad Triphasic</i>)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Levonorgestrel-Ethinyl Estrad (Aubra Eq)	T1	
Norethindrone Acet-Ethinyl Est (Aurovela 1.5/30)	T1	
Norethindrone Acet-Ethinyl Est (Aurovela 1/20)	T1	
Norethin Ace-Eth Estrad-FE (Aurovela Fe 1.5/30)	T1	
Norethin Ace-Eth Estrad-FE (Aurovela Fe 1/20)	T1	
AVERI (Desogestrel-Eth Estrad-FE)	T1	
Levonorgestrel-Ethinyl Estrad (Aviane)	T1	
Levonorgestrel-Ethinyl Estrad (Ayuna)	T1	
Desogestrel-Ethinyl Estradiol (Azurette)	T1	
Norethindrone-Eth Estradiol (Balziva)	T1	
Norethin Ace-Eth Estrad-FE (Blisovi Fe 1.5/30)	T1	
Norethin Ace-Eth Estrad-FE (Blisovi Fe 1/20)	T1	
Briellyn	T1	
Levonorgestrel-Ethinyl Estrad (Chateal Eq)	T1	
CLIMARA PRO (Estradiol-Levonorgestrel)	T1	PA
COMBIPATCH (Estradiol-Norethindrone Acet)	T1	ST
CRINONE (Progesterone)	T1	PA
Norgestrel-Ethinyl Estradiol (Cryselle-28)	T1	
Desogestrel-Ethinyl Estradiol (Cyred Eq)	T1	
Norethindrone-Eth Estradiol (Dasetta 1/35 (28))	T1	
Norethin-Eth Estrad Triphasic (Dasetta 7/7/7)	T1	
Norethindrone (Deblitane)	T1	
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE (MedroxyPROGESTERone Acetate)	T1	PA
Desogestrel-Ethinyl Estradiol Oral Tablet 0.15-0.02/0.01 MG (21/5)	T1	
Drospiren-Eth Estrad-Levomefol	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Drospirenone-Ethinyl Estradiol</i>	T1	
ECONTRA ONE-STEP (<i>Levonorgestrel</i>)	T1	
<i>Norgestrel-Ethinyl Estradiol</i> (Elinest)	T1	
ELLA (<i>Ulipristal Acetate</i>)	T1	
<i>Etonogestrel-Ethinyl Estradiol</i> (Eluryng)	T1	
<i>Desogestrel-Ethinyl Estradiol</i> (Enskyce Oral Tablet 0.15-30 Mg-Mcg)	T1	
<i>Norgestimate-Eth Estradiol</i> (Estarylla)	T1	
<i>Estradiol-Norethindrone Acet Oral Tablet 1-0.5 MG</i>	T1	PA
<i>Ethinodiol Diac-Eth Estradiol</i>	T1	
<i>Etonogestrel-Ethinyl Estradiol</i>	T1	
<i>Levonorgestrel-Ethinyl Estrad</i> (Falmina)	T1	
<i>Norethin Ace-Eth Estrad-FE</i> (Feirza 1.5/30)	T1	
<i>Norethin Ace-Eth Estrad-FE</i> (Feirza 1/20)	T1	
FEMLYV (<i>Norethindrone Acet-Ethinyl Est</i>)	T1	
<i>Norethindrone-Eth Estradiol</i> (Fyavolv Oral Tablet 1-5 Mg-Mcg)	T1	PA
<i>Norethin-Eth Estradiol-Fe</i> (Galbriela)	T1	
<i>Norethindrone Acet-Ethinyl Est</i> (Hailey 1.5/30)	T1	
<i>Norethin Ace-Eth Estrad-FE</i> (Hailey Fe 1.5/30)	T1	
<i>Norethin Ace-Eth Estrad-FE</i> (Hailey Fe 1/20)	T1	
<i>Etonogestrel-Ethinyl Estradiol</i> (Haloette)	T1	
<i>Norethindrone</i> (Heather)	T1	
HER STYLE (<i>Levonorgestrel</i>)	T1	
<i>Levonorgest-Eth Estrad 91-Day</i> (Iclevia)	T1	
<i>Norethindrone</i> (Incassia)	T1	
<i>Desogestrel-Ethinyl Estradiol</i> (Isibloom)	T1	
<i>Drospirenone-Ethinyl Estradiol</i> (Jasmiel)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Norethindrone-Eth Estradiol</i> (Jinteli)	T1	PA
<i>Levonorgest-Eth Estrad 91-Day</i> (Jolessa)	T1	
<i>Desogestrel-Ethinyl Estradiol</i> (Juleber)	T1	
<i>Norethindrone Acet-Ethinyl Est</i> (Junel 1.5/30)	T1	
<i>Norethindrone Acet-Ethinyl Est</i> (Junel 1/20)	T1	
<i>Norethin Ace-Eth Estrad-FE</i> (Junel Fe 1.5/30)	T1	
<i>Norethin Ace-Eth Estrad-FE</i> (Junel Fe 1/20)	T1	
<i>Desogestrel-Ethinyl Estradiol</i> (Kalliga)	T1	
<i>Desogestrel-Ethinyl Estradiol</i> (Kariva)	T1	
<i>Ethinodiol Diac-Eth Estradiol</i> (Kelnor 1/35)	T1	
KYLEENA (<i>Levonorgestrel</i>)	T1	
<i>Norethindrone Acet-Ethinyl Est</i> (Larin 1.5/30)	T1	
<i>Norethindrone Acet-Ethinyl Est</i> (Larin 1/20)	T1	
<i>Norethin Ace-Eth Estrad-FE</i> (Larin Fe 1.5/30)	T1	
<i>Norethin Ace-Eth Estrad-FE</i> (Larin Fe 1/20)	T1	
<i>Levonorgestrel-Ethinyl Estrad</i> (Lessina)	T1	
<i>Levonorg-Eth Estrad Triphasic</i> (Levonest)	T1	
<i>Levonorgest-Eth Est & Eth Est</i>	T1	
<i>Levonorgest-Eth Estrad 91-Day</i>	T1	
<i>Levonorgest-Eth Estradiol-Iron</i>	T1	
<i>Levonorgestrel Oral Tablet 1.5 MG</i>	T1	
<i>Levonorgestrel-Ethinyl Estrad</i>	T1	
<i>Levonorg-Eth Estrad Triphasic Oral Tablet 50-30/75-40/125-30 MCG</i>	T1	
<i>Levonorgestrel-Ethinyl Estrad</i> (Levora 0.15/30 (28))	T1	
LILETTA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 20.1 MCG/DAY (<i>Levonorgestrel</i>)	T1	
LO LOESTRIN FE (<i>Norethin-Eth Estrad-Fe Biphas</i>)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Drospirenone-Ethinyl Estradiol</i> (Loryna)	T1	
<i>Norgestrel-Ethinyl Estradiol</i> (Low-Ogestrel)	T1	
<i>Drospirenone-Ethinyl Estradiol</i> (Lo-Zumandimine)	T1	
<i>Levonorgestrel-Ethinyl Estrad</i> (Lutera)	T1	
<i>Norethindrone</i> (Lyleq)	T1	
<i>Norethindrone</i> (Lyza)	T1	
<i>Marlissa</i>	T1	
<i>medroxyPROGESTERone Acetate Intramuscular</i>	T1	
<i>medroxyPROGESTERone Acetate Oral</i>	T1	
<i>Megestrol Acetate Oral Suspension 40 MG/ML</i>	T1	
<i>Megestrol Acetate Oral Tablet</i>	T1	
<i>Norethindrone Acet-Ethinyl Est</i> (Microgestin 1.5/30)	T1	
<i>Norethindrone Acet-Ethinyl Est</i> (Microgestin 1/20)	T1	
<i>Norethin Ace-Eth Estrad-FE</i> (Microgestin Fe 1.5/30)	T1	
<i>Norethin Ace-Eth Estrad-FE</i> (Microgestin Fe 1/20)	T1	
<i>Norgestimate-Eth Estradiol</i> (Mili)	T1	
<i>Estradiol-Norethindrone Acet</i> (Mimvey)	T1	PA
MIRENA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 20 MCG/DAY (<i>Levonorgestrel</i>)	T1	
<i>Norgestimate-Eth Estradiol</i> (Mono-Linyah)	T1	
MY CHOICE (<i>Levonorgestrel</i>)	T1	
MY WAY (<i>Levonorgestrel</i>)	T1	
NATAZIA (<i>Estradiol Valerate-Dienogest</i>)	T1	
<i>Norethindrone-Eth Estradiol</i> (Necon 0.5/35 (28))	T1	
NEW DAY (<i>Levonorgestrel</i>)	T1	
NEXPLANON (<i>Etonogestrel</i>)	T1	
NEXTSTELLIS (<i>Drospirenone-Estetrol</i>)	T1	
<i>Drospirenone-Ethinyl Estradiol</i> (Nikki)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Norethindrone</i> (Nora-Be)	T1	
<i>Norelgestromin-Eth Estradiol</i>	T1	
<i>Norethin Ace-Eth Estrad-FE Oral Capsule</i>	T1	
<i>Norethin Ace-Eth Estrad-FE Oral Tablet 1.5-30 MG-MCG</i>	T1	
<i>Norethin Ace-Eth Estrad-FE Oral Tablet Chewable</i>	T1	
<i>Norethindrone Acetate Oral</i>	T1	
<i>Norethindrone Acet-Ethinyl Est Oral Tablet</i>	T1	
<i>Norethindrone Oral</i>	T1	
<i>Norethindrone-Eth Estradiol Oral Tablet 1-5 MG-MCG</i>	T1	PA
<i>Norethin-Eth Estradiol-Fe Oral Tablet Chewable 0.4-35 MG-MCG</i>	T1	
<i>Norgestimate-Eth Estradiol Oral Tablet 0.25-35 MG-MCG</i>	T1	
<i>Norgestim-Eth Estrad Triphasic</i>	T1	
<i>Norethindrone</i> (Norlyda)	T1	
<i>Norethindrone-Eth Estradiol</i> (Nortrel 0.5/35 (28))	T1	
<i>Norethindrone-Eth Estradiol</i> (Nortrel 1/35 (21))	T1	
<i>Norethindrone-Eth Estradiol</i> (Nortrel 1/35 (28))	T1	
<i>Norethin-Eth Estrad Triphasic</i> (Nortrel 7/7/7)	T1	
<i>Norethindrone-Eth Estradiol</i> (Nylia 1/35)	T1	
<i>Norethin-Eth Estrad Triphasic</i> (Nylia 7/7/7)	T1	
OPCICON ONE-STEP (<i>Levonorgestrel</i>)	T1	
OPILL (<i>Norgestrel</i>)	T1	
OPTION 2 (<i>Levonorgestrel</i>)	T1	
<i>Levonorgestrel-Ethinyl Estrad</i> (Orsythia)	T1	
<i>Norethindrone-Eth Estradiol</i> (Philith)	T1	
<i>Desogestrel-Ethinyl Estradiol</i> (Pimtreea)	T1	
<i>Norethin-Eth Estrad Triphasic</i> (Pirmella 7/7/7)	T1	
<i>Levonorgestrel-Ethinyl Estrad</i> (Portia-28)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PREMPHASE (<i>Conj Estrog-Medroxyprogest Ace</i>)	T1	
PREMPRO (<i>Conj Estrog-Medroxyprogest Ace</i>)	T1	
<i>Progesterone Oral</i>	T1	QL (30 EA per 30 days)
<i>Desogestrel-Ethinyl Estradiol</i> (Reclipsen)	T1	
<i>Levonorgest-Eth Estrad 91-Day</i> (Rosyrah)	T1	
<i>Levonorgest-Eth Estrad 91-Day</i> (Setlakin)	T1	
<i>Norethindrone</i> (Sharobel)	T1	
<i>Desogestrel-Ethinyl Estradiol</i> (Simliya)	T1	
SKYLA (<i>Levonorgestrel</i>)	T1	
SLYND (<i>Drospirenone</i>)	T1	
<i>Norgestimate-Eth Estradiol</i> (Sprintec 28)	T1	
<i>Levonorgestrel-Ethinyl Estrad</i> (Sronyx)	T1	
<i>Drospirenone-Ethinyl Estradiol</i> (Syeda)	T1	
<i>Norethin Ace-Eth Estrad-FE</i> (Tarina Fe 1/20 Eq)	T1	
<i>Norethindron-Ethinyl Estrad-Fe</i> (Tilia Fe)	T1	
<i>Norgestim-Eth Estrad Triphasic</i> (Tri Femynor)	T1	
<i>Norgestim-Eth Estrad Triphasic</i> (Tri-Estarylla)	T1	
<i>Norethindron-Ethinyl Estrad-Fe</i> (Tri-Legest Fe)	T1	
<i>Norgestim-Eth Estrad Triphasic</i> (Tri-Linyah)	T1	
<i>Norgestim-Eth Estrad Triphasic</i> (Tri-Lo-Estarylla)	T1	
<i>Norgestim-Eth Estrad Triphasic</i> (Tri-Lo-Marzia)	T1	
<i>Norgestim-Eth Estrad Triphasic</i> (Tri-Lo-Mili)	T1	
<i>Norgestim-Eth Estrad Triphasic</i> (Tri-Lo-Sprintec)	T1	
<i>Norgestim-Eth Estrad Triphasic</i> (Tri-Mili)	T1	
<i>Norgestim-Eth Estrad Triphasic</i> (Tri-Sprintec)	T1	
<i>Levonorg-Eth Estrad Triphasic</i> (Trivora (28))	T1	
<i>Norgestim-Eth Estrad Triphasic</i> (Tri-Vylibra)	T1	
<i>Norgestim-Eth Estrad Triphasic</i> (Tri-Vylibra Lo)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TWIRLA (<i>Levonorgestrel-Eth Estradiol</i>)	T1	
TYBLUME ORAL TABLET CHEWABLE (<i>Levonorgestrel-Ethinyl Estrad</i>)	T1	
<i>Ethinodiol Diac-Eth Estradiol</i> (Valtya 1/50)	T1	
VELIVET (<i>Desogestrel-Ethinyl Estradiol</i>)	T1	
<i>Drospirenone-Ethinyl Estradiol</i> (Vestura)	T1	
<i>Levonorgestrel-Ethinyl Estrad</i> (Vienna)	T1	
<i>Viorele</i>	T1	
<i>Desogestrel-Ethinyl Estradiol</i> (Volnea)	T1	
<i>Norgestimate-Eth Estradiol</i> (Vylibra)	T1	
<i>Norethindrone-Eth Estradiol</i> (Wera)	T1	
<i>Norethin-Eth Estradiol-Fe</i> (Xelria Fe)	T1	
<i>Ethinodiol Diac-Eth Estradiol</i> (Zovia 1/35 (28))	T1	
<i>Drospirenone-Ethinyl Estradiol</i> (Zumandimine)	T1	
Rapid-Acting Insulins		
APIDRA (<i>Insulin Glulisine</i>)	T1	QL (30 ML per 30 days)
APIDRA SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>Insulin Glulisine</i>)	T1	QL (30 ML per 30 days)
HUMALOG MIX 50/50 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (<i>Insulin Lispro Prot & Lispro</i>)	T1	QL (20 ML per 30 days)
HUMALOG MIX 75/25 (<i>Insulin Lispro Prot & Lispro</i>)	T1	QL (30 ML per 30 days)
HUMALOG SUBCUTANEOUS SOLUTION CARTRIDGE (<i>Insulin Lispro</i>)	T1	QL (30 ML per 30 days)
<i>Insulin Asp Prot & Asp FlexPen</i>	T1	QL (30 ML per 30 days)
<i>Insulin Aspart FlexPen</i>	T1	QL (30 ML per 30 days)
<i>Insulin Aspart Injection</i>	T1	QL (30 ML per 30 days)
<i>Insulin Aspart PenFill</i>	T1	QL (20 ML per 30 days)
<i>Insulin Aspart Prot & Aspart</i>	T1	QL (30 ML per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Insulin Lispro (1 Unit Dial)</i>	T1	QL (30 ML per 30 days)
<i>Insulin Lispro Injection</i>	T1	QL (30 ML per 30 days)
<i>Insulin Lispro Prot & Lispro</i>	T1	QL (30 ML per 30 days)
Short-Acting Insulins		
HUMULIN 70/30 (<i>Insulin NPH Isophane & Regular</i>)	T1	QL (20 ML per 30 days)
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (<i>Insulin NPH Isophane & Regular</i>)	T1	QL (20 ML per 30 days)
HUMULIN R (<i>Insulin Regular Human</i>)	T1	QL (20 ML per 30 days)
HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>Insulin Regular Human</i>)	T1	QL (12 ML per 30 days)
NOVOLIN 70/30 (<i>Insulin NPH Isophane & Regular</i>)	T1	QL (20 ML per 30 days)
NOVOLIN 70/30 FLEXPEN (<i>Insulin NPH Isophane & Regular</i>)	T1	QL (20 ML per 30 days)
NOVOLIN R (<i>Insulin Regular Human</i>)	T1	QL (120 ML per 30 days)
NOVOLIN R FLEXPEN (<i>Insulin Regular Human</i>)	T1	QL (20 ML per 30 days)
NOVOLIN R RELION (<i>Insulin Regular Human</i>)	T1	QL (20 ML per 30 days)
Sodium-Gluc Cotransport 2 (Sglt2) Inhib		
FARXIGA (<i>Dapagliflozin Propanediol</i>)	T1	QL (30 EA per 30 days)
INVOKAMET (<i>Canagliflozin-Metformin HCl</i>)	T1	QL (60 EA per 30 days)
INVOKANA (<i>Canagliflozin</i>)	T1	QL (30 EA per 30 days)
JARDIANCE (<i>Empagliflozin</i>)	T1	QL (30 EA per 30 days)
SYNJARDY (<i>Empagliflozin-Metformin HCl</i>)	T1	QL (60 EA per 30 days)
SYNJARDY XR (<i>Empagliflozin-Metformin HCl</i>)	T1	QL (30 EA per 30 days)
XIGDUO XR (<i>Dapagliflozin Prop-metFORMIN</i>)	T1	QL (30 EA per 30 days)
Somatostatin Agonists		
<i>Octreotide Acetate Injection Solution 100 MCG/ML, 1000 MCG/ML, 200 MCG/ML, 50 MCG/ML, 500 MCG/ML</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Somatotropin Agonists		
GENOTROPIN MINIQUICK SUBCUTANEOUS PREFILLED SYRINGE (<i>Somatropin</i>)	T1	PA
GENOTROPIN SUBCUTANEOUS CARTRIDGE (<i>Somatropin</i>)	T1	PA
HUMATROPE INJECTION CARTRIDGE (<i>Somatropin</i>)	T1	PA
NORDITROPIN FLEXPOR SUBCUTANEOUS SOLUTION PEN-INJECTOR 15 MG/1.5ML, 5 MG/1.5ML (<i>Somatropin</i>)	T1	PA
NUTROPIN AQ NUSPIN 10 SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>Somatropin</i>)	T1	PA
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 5 MG/1.5ML (<i>Somatropin</i>)	T1	PA
SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG (<i>Somatropin (Non-Refrigerated)</i>)	T1	PA
ZOMACTON (<i>Somatropin</i>)	T1	PA
Somatotropin Antagonists		
SOMAVERT SUBCUTANEOUS SOLUTION RECONSTITUTED 10 MG, 15 MG, 20 MG (<i>Pegvisomant</i>)	T1	
Sulfonylureas		
<i>Glimepiride Oral Tablet 1 MG, 2 MG, 4 MG</i>	T1	
<i>glipiZIDE ER</i>	T1	
<i>glipiZIDE Oral Tablet 10 MG, 5 MG</i>	T1	
<i>glipiZIDE-metFORMIN HCl</i>	T1	
<i>glyBURIDE Oral</i>	T1	
<i>GlyBURIDE-MetFORMIN Oral Tablet 1.25-250 MG</i>	T1	PA
<i>glyBURIDE-metFORMIN Oral Tablet 2.5-500 MG, 5-500 MG</i>	T1	
Thiazolidinediones		

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Alogliptin-Pioglitazone Oral Tablet 12.5-30 MG, 25-15 MG, 25-30 MG, 25-45 MG</i>	T1	ST
<i>Pioglitazone HCl</i>	T1	
Thyroid Agents		
ARMOUR THYROID (<i>Thyroid</i>)	T1	
<i>Levothyroxine Sodium</i> (Levo-T)	T1	
<i>Levothyroxine Sodium Oral Tablet</i>	T1	
<i>Levothyroxine Sodium</i> (Levoxyl)	T1	
<i>Liothyronine Sodium Oral</i>	T1	
<i>Niva Thyroid</i>	T1	
NP THYROID (<i>Thyroid</i>)	T1	
SYNTHROID (<i>Levothyroxine Sodium</i>)	T1	
<i>Thyroid Oral Tablet 120 MG, 15 MG, 30 MG, 60 MG, 90 MG</i>	T1	
<i>Levothyroxine Sodium</i> (Unithroid)	T1	
Immunomodulatory Agents (90:00)		
Amino Acid Polymers		
<i>Glatiramer Acetate</i>	T1	
Antimetabolites, Immunosupp Therapy Misc		
<i>azaTHIOprine Oral Tablet 50 MG</i>	T1	
<i>AzaTHIOprine Sodium</i>	T1	PA
<i>Mycophenolate Mofetil Oral Capsule</i>	T1	
Calcineurin Inhibitors, Misc (90:28)		
CEQUA (<i>CycloSPORINE</i>)	T1	PA
<i>CycloSPORINE Modified</i>	T1	
<i>cycloSPORINE Ophthalmic</i>	T1	PA
<i>CycloSPORINE Oral Capsule</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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<i>CycloSPORINE Modified</i> (Gengraf Oral Capsule 100 Mg, 25 Mg)	T1	
<i>CycloSPORINE Modified</i> (Gengraf Oral Solution)	T1	
NEORAL (<i>CycloSPORINE Modified</i>)	T1	
PROGRAF ORAL CAPSULE (<i>Tacrolimus</i>)	T1	
SANDIMMUNE ORAL CAPSULE (<i>CycloSPORINE</i>)	T1	
<i>Tacrolimus External Ointment</i>	T1	QL (30 GM per 30 days)
<i>Tacrolimus Oral</i>	T1	
Disease-Modifying Antirheumat Drugs Misc		
ENTYVIO INTRAVENOUS (<i>Vedolizumab</i>)	T1	PA
ORENCIA INTRAVENOUS (<i>Abatacept</i>)	T1	PA
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML (<i>Abatacept</i>)	T1	PA
Disease-Modifying Antirheumatic Drugs		
AVSOLA (<i>inFLIXimab-axxq</i>)	T1	PA
<i>Hydroxychloroquine Sulfate Oral Tablet 200 MG</i>	T1	
INFLECTRA (<i>InFLIXimab-dyyb</i>)	T1	PA
<i>inFLIXimab</i>	T1	PA
<i>Methotrexate Sodium (PF) Injection Solution 1 GM/40ML, 1000 MG/40ML, 250 MG/10ML, 50 MG/2ML</i>	T1	
<i>Methotrexate Sodium Injection Solution 250 MG/10ML, 50 MG/2ML</i>	T1	
<i>Methotrexate Sodium Oral</i>	T1	
RENFLEXIS (<i>InFLIXimab-abda</i>)	T1	PA
<i>sulfaSALazine Oral</i>	T1	
Fumarates		
<i>Dimethyl Fumarate Oral</i>	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Dimethyl Fumarate Starter Pack Oral Capsule Delayed Release Therapy Pack</i>	T1	PA
Immunomodulatory Agents (90:00)		
<i>Cyclophosphamide Oral Tablet 50 MG</i>	T1	
<i>Mercaptopurine Oral Tablet</i>	T1	
Interferons		
AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT (<i>Interferon Beta-1a</i>)	T1	
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT (<i>Interferon Beta-1a</i>)	T1	
BETASERON SUBCUTANEOUS KIT (<i>Interferon Beta-1b</i>)	T1	
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>Peginterferon alfa-2a</i>)	T1	PA
REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>Interferon Beta-1a</i>)	T1	
REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>Interferon Beta-1a</i>)	T1	
Interleukin Inhibitor Agents, Misc		
XOLAIR (<i>Omalizumab</i>)	T1	PA
Interleukin-Mediated Agents, Misc		
IMULDOSA SUBCUTANEOUS (<i>Ustekinumab-srlf</i>)	T1	PA
KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>Sarilumab</i>)	T1	PA
KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML (<i>Sarilumab</i>)	T1	PA
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>Anakinra</i>)	T1	PA
OTULFI SUBCUTANEOUS (<i>Ustekinumab-aaaz</i>)	T1	PA
SELARSDI SUBCUTANEOUS (<i>Ustekinumab-aekn</i>)	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TYENNE SUBCUTANEOUS (<i>Tocilizumab-aazg</i>)	T1	PA
YESINTEK SUBCUTANEOUS (<i>Ustekinumab-kfce</i>)	T1	PA
Janus Kinase Inhibitors, Miscellaneous		
OLUMIANT (<i>Baricitinib</i>)	T1	PA
XELJANZ (<i>Tofacitinib Citrate</i>)	T1	PA
XELJANZ XR (<i>Tofacitinib Citrate</i>)	T1	PA
Monocarboxylic Acid Amide Agents		
<i>Leflunomide Oral</i>	T1	
Mtor Inhibitors, Miscellaneous		
<i>Sirolimus Oral</i>	T1	
Phosphodiesterase-4 Inhibitors, Misc		
OTEZLA ORAL TABLET (<i>Apremilast</i>)	T1	PA
OTEZLA ORAL TABLET THERAPY PACK (<i>Apremilast</i>)	T1	PA
OTEZLA XR (<i>Apremilast</i>)	T1	PA
OTEZLA/OTEZLA XR INITIATION PK (<i>Apremilast</i>)	T1	PA
Sphingosine 1-Phosphate (S1p) Agents		
<i>Fingolimod HCl</i>	T1	PA
Tumor Necrosis Factor Inhibitors, Misc		
<i>Adalimumab-aaty (1 Pen) Subcutaneous Auto-Injector Kit 40 MG/0.4ML</i>	T1	QL (4 EA per 28 days)
<i>Adalimumab-aaty (1 Pen) Subcutaneous Auto-Injector Kit 80 MG/0.8ML</i>	T1	QL (2 EA per 28 days)
<i>Adalimumab-aaty (2 Pen)</i>	T1	QL (2 EA per 28 days)
<i>Adalimumab-aaty (2 Syringe)</i>	T1	QL (2 EA per 28 days)
<i>Adalimumab-aaty CD/UC/HS Start</i>	T1	QL (2 EA per 28 days)
<i>Adalimumab-fkjp (2 Pen)</i>	T1	QL (4 EA per 28 days)
<i>Adalimumab-fkjp (2 Syringe)</i>	T1	QL (4 EA per 28 days)

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bold italics = Generic drugs UPPERCASE = Brand name drugs	Drug Tier	Coverage Requirements and Limits
	SCO = State Carve Out T1 = Preferred Medication T2 = Preferred Medication with Restriction T3 = Non-Preferred Medication - Prior Authorization is Required	AL = Age Limit PA = Prior Authorization QL = Quantity Limit SCO = State Carve Out ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AVSOLA (<i>inFLIXimab-axxq</i>)	T1	PA
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (<i>Etanercept</i>)	T1	PA
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>Etanercept</i>)	T1	PA
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>Etanercept</i>)	T1	PA
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML (<i>Adalimumab-bwwd</i>)	T1	QL (1.6 ML per 28 days)
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.8ML (<i>Adalimumab-bwwd</i>)	T1	QL (3.2 ML per 28 days)
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML (<i>Adalimumab-bwwd</i>)	T1	QL (1.6 ML per 28 days)
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.8ML (<i>Adalimumab-bwwd</i>)	T1	QL (3.2 ML per 28 days)
INFLECTRA (<i>InFLIXimab-dyyb</i>)	T1	PA
<i>inFLIXimab</i>	T1	PA
RENFLEXIS (<i>InFLIXimab-abda</i>)	T1	PA
SIMLANDI (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML (<i>Adalimumab-ryvk</i>)	T1	QL (4 EA per 28 days)
SIMLANDI (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML (<i>Adalimumab-ryvk</i>)	T1	QL (2 EA per 28 days)
SIMLANDI (2 PEN) (<i>Adalimumab-ryvk</i>)	T1	QL (4 EA per 28 days)
SIMLANDI (2 SYRINGE) (<i>Adalimumab-ryvk</i>)	T1	QL (4 EA per 28 days)
SIMPONI ARIA (<i>Golimumab</i>)	T1	PA
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>Golimumab</i>)	T1	PA
Local Anesthetics		
Local Anesthetics		

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>BU</i>Pivacaine Fisiopharma Injection Solution 0.5 %, 2.5 MG/ML	T1	
<i>Bupivacaine HCl (PF)</i>	T1	
<i>BU</i>Pivacaine HCl Injection Solution 0.25 %, 0.5 %	T1	
<i>Bupivacaine HCl-NaCl Epidural Solution 0.125-0.9 %</i>	T1	
<i>BU</i>Pivacaine in Dextrose Intrathecal	T1	
<i>Bupivacaine Spinal</i>	T1	
<i>Bupivacaine-Epinephrine (PF) Injection Solution 0.25% - 1:200000, 0.5% -1:200000</i>	T1	
<i>BU</i>Pivacaine-EPINEPHrine Injection Solution 0.25% - 1:200000, 0.5% -1:200000	T1	
<i>Chloroprocaine HCl (PF) Injection Solution 2 %</i>	T1	
<i>Chloroprocaine HCl (PF) Injection Solution 3 %</i>	T1	PA
<i>Fentanyl Cit-Ropivacaine-NaCl Epidural Solution 0.2-0.2-0.9 MG/100ML-%, 0.5-0.2-0.9 MG/250ML-%</i>	T1	
<i>Fentanyl-Bupivacaine-NaCl Epidural Solution 0.2-0.1-0.9 MG/100ML-%, 0.2-0.125-0.9 MG/100ML-%, 0.5-0.1-0.9 MG/250ML-%, 0.5-0.125-0.9 MG/250ML-%</i>	T1	
<i>Lidocaine HCl (PF) Injection Solution 0.5 %</i>	T1	
<i>Lidocaine HCl Injection Solution 0.5 %, 1 %, 2 %</i>	T1	
<i>Lidocaine HCl Injection Solution Prefilled Syringe 200 MG/10ML</i>	T1	
<i>Lidocaine-EPINEPHrine Injection Solution 0.5 %-1:200000, 1 %-1:100000, 2 %-1:100000</i>	T1	
<i>POLOCAINE (Mepivacaine HCl)</i>	T1	
<i>POLOCAINE-MPF (Mepivacaine HCl)</i>	T1	
<i>RO</i>Pivacaine HCl Injection Solution 10 MG/ML, 2 MG/ML, 5 MG/ML, 7.5 MG/ML	T1	
<i>Ropivacaine HCl-NaCl Injection Solution 0.2-0.9 %</i>	T1	
<i>Bupivacaine-Epinephrine (Sensorcaine/Epinephrine)</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Bupivacaine HCl</i> (Sensorcaine-Mpf Injection Solution 0.75 %)	T1	
<i>Bupivacaine-Epinephrine</i> (Sensorcaine-Mpf/Epinephrine Injection Solution 0.25% -1:200000)	T1	
SENSORCAINE-MPF/EPINEPHRINE INJECTION SOLUTION 0.75-1:200000 % (<i>Bupivacaine-Epinephrine</i>)	T1	
<i>Tetracaine HCl Ophthalmic</i>	T1	
XYLOCAINE-MPF/EPINEPHRINE INJECTION SOLUTION 1 %-1:200000 (<i>Lidocaine-Epinephrine</i>)	T1	
Miscellaneous Therapeutic Agents		
5-Alpha-Reductase Inhibitors		
<i>Finasteride Oral Tablet 5 MG</i>	T1	
5-Alpha-Reductase Inhibitors (92:04)		
<i>Disulfiram Oral</i>	T1	
<i>Finasteride Oral Tablet 5 MG</i>	T1	
<i>Naltrexone HCl Oral</i>	T1	
VIVITROL (<i>Naltrexone</i>)	T1	
Antidotes (92:12)		
<i>Acetylcysteine Inhalation</i>	T1	
<i>Atropine Sulfate Injection Solution 8 MG/20ML</i>	T1	
<i>Atropine Sulfate Injection Solution Prefilled Syringe 0.25 MG/5ML, 0.5 MG/5ML, 1 MG/10ML</i>	T1	
BAQSIMI ONE PACK (<i>Glucagon</i>)	T1	
BAQSIMI TWO PACK (<i>Glucagon</i>)	T1	
CHEMET (<i>Succimer</i>)	T1	
<i>Deferoxamine Mesylate</i>	T1	PA
<i>Glucagon Emergency Injection Solution Reconstituted</i>	T1	
<i>Iodine Strong Oral</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Lanthanum Carbonate</i>	T1	PA
LEDERLE LEUCOVORIN (<i>Leucovorin Calcium</i>)	T1	
<i>Leucovorin Calcium Oral Tablet 5 MG</i>	T1	
<i>Magnesium Sulfate Injection Solution 50 %</i>	T1	
<i>Naloxone HCl Injection Solution 0.4 MG/ML, 4 MG/10ML</i>	T1	
<i>Naloxone HCl Injection Solution Cartridge</i>	T1	
<i>Naloxone HCl Injection Solution Prefilled Syringe 2 MG/2ML</i>	T1	
<i>Naltrexone HCl Oral</i>	T1	
<i>Phytonadione Injection Solution 1 MG/0.5ML, 10 MG/ML</i>	T1	
<i>Phytonadione Oral</i>	T1	
<i>Sevelamer Carbonate Oral Tablet</i>	T1	
<i>Sevelamer HCl</i>	T1	PA
<i>Vitamin K1 Injection Solution 1 MG/0.5ML, 10 MG/ML</i>	T1	
VIVITROL (<i>Naltrexone</i>)	T1	
Antigout Agents		
<i>Allopurinol Oral Tablet 100 MG, 300 MG</i>	T1	
<i>Colchicine Oral Capsule</i>	T1	PA
<i>Colchicine Oral Tablet</i>	T1	QL (30 EA per 30 days)
<i>Colchicine-Probenecid</i>	T1	
<i>EC-Naproxen Oral Tablet Delayed Release 500 MG</i>	T1	
<i>Indomethacin ER</i>	T1	
<i>Indomethacin Oral Capsule 25 MG, 50 MG</i>	T1	
<i>Indomethacin Oral Suspension</i>	T1	
<i>Naproxen Oral</i>	T1	
<i>Naproxen Sodium ER Oral Tablet Extended Release 24 Hour 375 MG, 500 MG</i>	T1	
<i>Naproxen Sodium Oral Tablet 275 MG, 550 MG</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Probenecid Oral</i>	T1	
Bone Anabolic Agents		
<i>Teriparatide Subcutaneous Solution Pen-Injector 560 MCG/2.24ML</i>	T1	PA
Bone Resorption Inhibitors		
<i>Alendronate Sodium Oral Solution</i>	T1	QL (75 ML per 30 days)
<i>Alendronate Sodium Oral Tablet 10 MG, 35 MG, 70 MG</i>	T1	
<i>Calcitonin (Salmon) Nasal</i>	T1	
DEPO-ESTRADIOL (<i>Estradiol Cypionate</i>)	T1	PA
<i>Estradiol</i> (Dotti)	T1	QL (8 EA per 28 days)
<i>Estradiol Oral</i>	T1	
<i>Estradiol Transdermal Gel 0.75 MG/1.25 GM (0.06%)</i>	T1	
<i>Estradiol Transdermal Patch Twice Weekly</i>	T1	QL (8 EA per 28 days)
<i>Estradiol Transdermal Patch Weekly</i>	T1	
<i>Estradiol Vaginal Cream 0.01 %</i>	T1	
<i>Estradiol Vaginal Tablet</i>	T1	
<i>Estradiol Valerate Intramuscular</i>	T1	PA
FEMRING (<i>Estradiol Acetate</i>)	T1	PA
FOSAMAX PLUS D ORAL TABLET 70-2800 MG-UNIT (<i>Alendronate-Cholecalciferol</i>)	T1	PA
<i>Ibandronate Sodium Oral</i>	T1	QL (1 EA per 28 days)
<i>Estradiol</i> (Lyllana)	T1	QL (8 EA per 28 days)
PREMARIN ORAL (<i>Estrogens Conjugated</i>)	T1	
PREMARIN VAGINAL (<i>Estrogens, Conjugated</i>)	T1	
<i>Raloxifene HCl</i>	T1	
<i>Risedronate Sodium Oral Tablet 150 MG</i>	T1	QL (1 EA per 30 days)
<i>Risedronate Sodium Oral Tablet 35 MG</i>	T1	QL (4 EA per 30 days)
<i>Risedronate Sodium Oral Tablet 5 MG</i>	T1	QL (30 EA per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Estradiol</i> (Yuvafem)	T1	
Cariostatic Agents		
DENTA 5000 PLUS (<i>Sodium Fluoride</i>)	T1	
<i>Multivitamin/Fluoride Oral Tablet Chewable 0.25 MG, 0.5 MG, 1 MG</i>	T1	
PREVIDENT DENTAL (<i>Sodium Fluoride</i>)	T1	
<i>SF</i>	T1	
<i>SF 5000 Plus</i>	T1	
<i>Sodium Fluoride 5000 Plus</i>	T1	
<i>Sodium Fluoride Dental Cream</i>	T1	
<i>Sodium Fluoride Dental Gel 1.1 %</i>	T1	
<i>Sodium Fluoride Mouth/Throat</i>	T1	
<i>Sodium Fluoride Oral Solution 1.1 (0.5 F) MG/ML</i>	T1	
<i>Sodium Fluoride Oral Tablet Chewable</i>	T1	
<i>Tri-Vite/Fluoride Oral Solution 0.25 MG/ML</i>	T1	
Disease-Modifying Antirheumatic Agents		
<i>Adalimumab-aaty (1 Pen) Subcutaneous Auto-Injector Kit 40 MG/0.4ML</i>	T1	QL (4 EA per 28 days)
<i>Adalimumab-aaty (1 Pen) Subcutaneous Auto-Injector Kit 80 MG/0.8ML</i>	T1	QL (2 EA per 28 days)
<i>Adalimumab-aaty (2 Pen)</i>	T1	QL (2 EA per 28 days)
<i>Adalimumab-aaty (2 Syringe)</i>	T1	QL (2 EA per 28 days)
<i>Adalimumab-aaty CD/UC/HS Start</i>	T1	QL (2 EA per 28 days)
<i>Adalimumab-fkjp (2 Pen)</i>	T1	QL (4 EA per 28 days)
<i>Adalimumab-fkjp (2 Syringe)</i>	T1	QL (4 EA per 28 days)
AVSOLA (<i>inFLIXimab-axxq</i>)	T1	PA
<i>azaTHIOprine Oral Tablet 50 MG</i>	T1	
<i>AzaTHIOprine Sodium</i>	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CycloSPORINE Modified	T1	
CycloSPORINE Oral Capsule	T1	
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (Etanercept)	T1	PA
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (Etanercept)	T1	PA
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR (Etanercept)	T1	PA
CycloSPORINE Modified (Gengraf Oral Capsule 100 Mg, 25 Mg)	T1	
CycloSPORINE Modified (Gengraf Oral Solution)	T1	
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML (Adalimumab-bwwd)	T1	QL (1.6 ML per 28 days)
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.8ML (Adalimumab-bwwd)	T1	QL (3.2 ML per 28 days)
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML (Adalimumab-bwwd)	T1	QL (1.6 ML per 28 days)
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.8ML (Adalimumab-bwwd)	T1	QL (3.2 ML per 28 days)
Hydroxychloroquine Sulfate Oral Tablet 200 MG	T1	
INFLECTRA (InFLIXimab-dyyb)	T1	PA
inFLIXimab	T1	PA
KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR (Sarilumab)	T1	PA
KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML (Sarilumab)	T1	PA
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (Anakinra)	T1	PA
Leflunomide Oral	T1	
Methotrexate Sodium (PF) Injection Solution 1 GM/40ML, 1000 MG/40ML, 250 MG/10ML, 50 MG/2ML	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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Drug Tier SCO = State Carve Out T1 = Preferred Medication T2 = Preferred Medication with Restriction T3 = Non-Preferred Medication - Prior Authorization is Required		
Coverage Requirements and Limits AL = Age Limit PA = Prior Authorization QL = Quantity Limit SCO = State Carve Out ST = Step Therapy		
<i>Methotrexate Sodium Injection Solution 250 MG/10ML, 50 MG/2ML</i>	T1	
<i>Methotrexate Sodium Oral</i>	T1	
NEORAL (<i>CycloSPORINE Modified</i>)	T1	
OLUMIANT (<i>Baricitinib</i>)	T1	PA
ORENCIA INTRAVENOUS (<i>Abatacept</i>)	T1	PA
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML (<i>Abatacept</i>)	T1	PA
OTEZLA ORAL TABLET 30 MG (<i>Apremilast</i>)	T1	PA
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (<i>Apremilast</i>)	T1	PA
<i>penicillAMINE Oral</i>	T1	PA
RENFLEXIS (<i>InFLIXimab-abda</i>)	T1	PA
SANDIMMUNE ORAL CAPSULE (<i>CycloSPORINE</i>)	T1	
SIMLANDI (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML (<i>Adalimumab-ryvk</i>)	T1	QL (4 EA per 28 days)
SIMLANDI (2 PEN) (<i>Adalimumab-ryvk</i>)	T1	QL (4 EA per 28 days)
SIMLANDI (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.4ML (<i>Adalimumab-ryvk</i>)	T1	QL (4 EA per 28 days)
SIMPONI ARIA (<i>Golimumab</i>)	T1	PA
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>Golimumab</i>)	T1	PA
<i>sulfaSALazine Oral</i>	T1	
XELJANZ (<i>Tofacitinib Citrate</i>)	T1	PA
XELJANZ XR (<i>Tofacitinib Citrate</i>)	T1	PA
Gonadotropin-Releasing Hormone Antagnts		
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG (<i>Degarelix Acetate</i>)	T1	QL (1 EA per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Ganirelix Acetate Subcutaneous Solution Prefilled Syringe</i>	T1	PA
Immunomodulatory Agents		
ACTIMMUNE (<i>Interferon Gamma-1B</i>)	T1	
<i>Adalimumab-aaty (1 Pen) Subcutaneous Auto-Injector Kit 40 MG/0.4ML</i>	T1	QL (4 EA per 28 days)
<i>Adalimumab-aaty (1 Pen) Subcutaneous Auto-Injector Kit 80 MG/0.8ML</i>	T1	QL (2 EA per 28 days)
<i>Adalimumab-aaty (2 Pen)</i>	T1	QL (2 EA per 28 days)
<i>Adalimumab-aaty (2 Syringe)</i>	T1	QL (2 EA per 28 days)
<i>Adalimumab-aaty CD/UC/HS Start</i>	T1	QL (2 EA per 28 days)
<i>Adalimumab-fkjp (2 Pen)</i>	T1	QL (4 EA per 28 days)
<i>Adalimumab-fkjp (2 Syringe)</i>	T1	QL (4 EA per 28 days)
AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT (<i>Interferon Beta-1a</i>)	T1	
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT (<i>Interferon Beta-1a</i>)	T1	
AVSOLA (<i>inFLIXimab-axxq</i>)	T1	PA
<i>azaTHIOprine Oral Tablet 50 MG</i>	T1	
<i>AzaTHIOprine Sodium</i>	T1	PA
BETASERON SUBCUTANEOUS KIT (<i>Interferon Beta-1b</i>)	T1	
<i>CycloSPORINE Modified</i>	T1	
<i>CycloSPORINE Oral Capsule</i>	T1	
<i>Dimethyl Fumarate Oral</i>	T1	PA
<i>Dimethyl Fumarate Starter Pack Oral Capsule Delayed Release Therapy Pack</i>	T1	PA
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (<i>Etanercept</i>)	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>Etanercept</i>)	T1	PA
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>Etanercept</i>)	T1	PA
ENTYVIO INTRAVENOUS (<i>Vedolizumab</i>)	T1	PA
<i>Fingolimod HCl</i>	T1	PA
<i>CycloSPORINE Modified</i> (Gengraf Oral Capsule 100 Mg, 25 Mg)	T1	
<i>CycloSPORINE Modified</i> (Gengraf Oral Solution)	T1	
<i>Glatiramer Acetate</i>	T1	
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML (<i>Adalimumab-bwwd</i>)	T1	QL (1.6 ML per 28 days)
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.8ML (<i>Adalimumab-bwwd</i>)	T1	QL (3.2 ML per 28 days)
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML (<i>Adalimumab-bwwd</i>)	T1	QL (1.6 ML per 28 days)
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.8ML (<i>Adalimumab-bwwd</i>)	T1	QL (3.2 ML per 28 days)
<i>Hydroxychloroquine Sulfate Oral Tablet 200 MG</i>	T1	
INFLECTRA (<i>InFLIXimab-dyyb</i>)	T1	PA
<i>inFLIXimab</i>	T1	PA
KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>Sarilumab</i>)	T1	PA
KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML (<i>Sarilumab</i>)	T1	PA
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>Anakinra</i>)	T1	PA
<i>Leflunomide Oral</i>	T1	
<i>Lenalidomide</i>	T1	PA

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bold italics = Generic drugs UPPERCASE = Brand name drugs	Drug Tier	Coverage Requirements and Limits
	SCO = State Carve Out T1 = Preferred Medication T2 = Preferred Medication with Restriction T3 = Non-Preferred Medication - Prior Authorization is Required	AL = Age Limit PA = Prior Authorization QL = Quantity Limit SCO = State Carve Out ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Methotrexate Sodium (PF) Injection Solution 1 GM/40ML, 1000 MG/40ML, 250 MG/10ML, 50 MG/2ML</i>	T1	
<i>Methotrexate Sodium Injection Solution 250 MG/10ML, 50 MG/2ML</i>	T1	
<i>Methotrexate Sodium Oral</i>	T1	
NEORAL (<i>CycloSPORINE Modified</i>)	T1	
OLUMIANT ORAL TABLET 1 MG, 2 MG (<i>Baricitinib</i>)	T1	PA
ORENCIA INTRAVENOUS (<i>Abatacept</i>)	T1	PA
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML (<i>Abatacept</i>)	T1	PA
OTEZLA ORAL TABLET (<i>Apremilast</i>)	T1	PA
OTEZLA ORAL TABLET THERAPY PACK (<i>Apremilast</i>)	T1	PA
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>Peginterferon alfa-2a</i>)	T1	PA
POMALYST (<i>Pomalidomide</i>)	T1	PA
REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>Interferon Beta-1a</i>)	T1	
REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>Interferon Beta-1a</i>)	T1	
RENFLEXIS (<i>InFLIXimab-abda</i>)	T1	PA
REVLIMID ORAL CAPSULE 10 MG, 15 MG, 25 MG, 5 MG (<i>Lenalidomide</i>)	T1	PA
SANDIMMUNE ORAL CAPSULE (<i>CycloSPORINE</i>)	T1	
SIMLANDI (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML (<i>Adalimumab-ryvk</i>)	T1	QL (4 EA per 28 days)
SIMLANDI (2 PEN) (<i>Adalimumab-ryvk</i>)	T1	QL (4 EA per 28 days)
SIMLANDI (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.4ML (<i>Adalimumab-ryvk</i>)	T1	QL (4 EA per 28 days)
SIMPONI ARIA (<i>Golimumab</i>)	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>Golimumab</i>)	T1	PA
<i>sulfaSALazine Oral</i>	T1	
THALOMID ORAL CAPSULE 100 MG, 50 MG (<i>Thalidomide</i>)	T1	PA
XELJANZ (<i>Tofacitinib Citrate</i>)	T1	PA
XELJANZ XR (<i>Tofacitinib Citrate</i>)	T1	PA
Immunosuppressive Agents		
<i>azaTHIOprine Oral Tablet 50 MG</i>	T1	
<i>AzaTHIOprine Sodium</i>	T1	PA
<i>Cyclophosphamide Oral Tablet 50 MG</i>	T1	
<i>CycloSPORINE Modified</i>	T1	
<i>CycloSPORINE Oral Capsule</i>	T1	
<i>CycloSPORINE Modified</i> (Gengraf Oral Capsule 100 Mg, 25 Mg)	T1	
<i>CycloSPORINE Modified</i> (Gengraf Oral Solution)	T1	
<i>Leflunomide Oral</i>	T1	
<i>Mercaptopurine Oral Tablet</i>	T1	
<i>Methotrexate Sodium (PF) Injection Solution 1 GM/40ML, 1000 MG/40ML, 250 MG/10ML, 50 MG/2ML</i>	T1	
<i>Methotrexate Sodium Injection Solution 250 MG/10ML, 50 MG/2ML</i>	T1	
<i>Methotrexate Sodium Oral</i>	T1	
<i>Mycophenolate Mofetil Oral</i>	T1	
<i>Mycophenolate Sodium</i>	T1	
NEORAL (<i>CycloSPORINE Modified</i>)	T1	
<i>Pimecrolimus</i>	T1	PA
PROGRAF ORAL CAPSULE (<i>Tacrolimus</i>)	T1	
SANDIMMUNE ORAL CAPSULE (<i>CycloSPORINE</i>)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Sirolimus Oral</i>	T1	
<i>Tacrolimus External Ointment</i>	T1	QL (30 GM per 30 days)
<i>Tacrolimus Oral</i>	T1	
Other Miscellaneous Therapeutic Agents		
<i>Acetic Acid Glacial Solution 99 %</i>	T1	
<i>Acetic Acid Solution 5 %</i>	T1	
<i>Acetylcysteine Inhalation</i>	T1	
<i>Betaine</i>	T1	
<i>BP Vit 3</i>	T1	
<i>Complete Natal DHA Oral 29-1-200 & 200 MG</i>	T1	
CYSTAGON (<i>Cysteamine Bitartrate</i>)	T1	
<i>Dalfampridine ER</i>	T1	PA
DYSPORT (<i>AbobotulinumtoxinA</i>)	T1	PA
ELMIRON (<i>Pentosan Polysulfate Sodium</i>)	T1	PA
<i>levOCARNitine Oral Tablet</i>	T1	
<i>levOCARNitine SF</i>	T1	
LODOCO (<i>Colchicine</i>)	T1	PA
<i>metyroSINE</i>	T1	
<i>Nitisinone Oral Capsule 10 MG, 2 MG, 5 MG</i>	T1	
<i>Octreotide Acetate Injection Solution 100 MCG/ML, 1000 MCG/ML, 200 MCG/ML, 50 MCG/ML, 500 MCG/ML</i>	T1	
<i>Prenatal Gummies/DHA & FA</i>	T1	
PRENATAL MULTIVITAMIN + DHA (<i>Prenatal MV-Min-Fe Fum-FA-DHA</i>)	T1	
<i>Tiopronin Oral Tablet</i>	T1	PA
XEOMIN (<i>IncobotulinumtoxinA</i>)	T1	PA
Protective Agents		
<i>Adapalene External Gel 0.1 %</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Adapalene External Pad</i>	T1	
<i>Adapalene External Solution</i>	T1	
<i>Adapalene-Benzoyl Peroxide External Gel 0.1-2.5 %</i>	T1	QL (45 GM per 30 days); AL (Max 30 Years)
<i>Dalfampridine ER</i>	T1	PA
ELMIRON (<i>Pentosan Polysulfate Sodium</i>)	T1	PA
<i>Mesna Oral</i>	T1	
Nonhormonal Contraceptives		
Nonhormonal Contraceptives		
<i>Aimsco Lubricated</i>	T1	
CAYA (<i>Diaphragm Arc-Spring</i>)	T1	
DUREX REALFEEL (<i>Condoms Non-Latex Lubricated</i>)	T1	
FANTASY LUBRICATED (<i>Condoms Latex Lubricated</i>)	T1	
FANTASY LUBRICATED/SPERMICIDE (<i>Condoms Latex Lubricated</i>)	T1	
FC2 FEMALE CONDOM (<i>Condoms - Female</i>)	T1	
FEMCAP (<i>Cervical Caps</i>)	T1	
<i>Kimono</i>	T1	
<i>Kimono Micro Thin</i>	T1	
<i>Kimono Micro Thin Plus</i>	T1	
<i>Kimono Sensation</i>	T1	
<i>Kimono Sensation Plus</i>	T1	
<i>Maxx</i>	T1	
MIUDELLA INTRAUTERINE COPPER (<i>Copper</i>)	T1	
OPTIONS GYNOL II CONTRACEPTIVE (<i>Nonoxynol-9</i>)	T1	
PARAGARD INTRAUTERINE COPPER (<i>Copper</i>)	T1	
TODAY SPONGE (<i>Nonoxynol-9</i>)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRUSTEX LUB/RIBBED/STUDED (<i>Condoms Latex Lubricated</i>)	T1	
TRUSTEX LUB/SPERMICIDE EX ST (<i>Condoms Latex Lubricated</i>)	T1	
TRUSTEX LUB/SPERMICIDE XL (<i>Condoms Latex Lubricated</i>)	T1	
TRUSTEX LUBRICATED (<i>Condoms Latex Lubricated</i>)	T1	
TRUSTEX LUBRICATED EX LARGE (<i>Condoms Latex Lubricated</i>)	T1	
TRUSTEX LUBRICATED EXTRA ST (<i>Condoms Latex Lubricated</i>)	T1	
TRUSTEX LUBRICATED/SPERMICIDE (<i>Condoms Latex Lubricated</i>)	T1	
TRUSTEX NON-LUBRICATED (<i>Condoms Latex Non-Lubricated</i>)	T1	
TRUSTEX RIA LUB/SPERMICIDE (<i>Condoms Latex Lubricated</i>)	T1	
TRUSTEX RIA LUBRICATED (<i>Condoms Latex Lubricated</i>)	T1	
TRUSTEX RIA NON-LUBRICATED (<i>Condoms Latex Non-Lubricated</i>)	T1	
TRUSTEX-NONOXYNOL-9/RIB/STUD (<i>Condoms Latex Lubricated</i>)	T1	
VCF VAGINAL CONTRACEPTIVE VAGINAL FILM (<i>Nonoxynol-9</i>)	T1	
VCF VAGINAL CONTRACEPTIVE VAGINAL GEL (<i>Nonoxynol-9</i>)	T1	
WIDE-SEAL DIAPHRAGM 60 (<i>Diaphragm Wide Seal</i>)	T1	
WIDE-SEAL DIAPHRAGM 65 (<i>Diaphragm Wide Seal</i>)	T1	
WIDE-SEAL DIAPHRAGM 70 (<i>Diaphragm Wide Seal</i>)	T1	
WIDE-SEAL DIAPHRAGM 75 (<i>Diaphragm Wide Seal</i>)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
WIDE-SEAL DIAPHRAGM 80 (<i>Diaphragm Wide Seal</i>)	T1	
WIDE-SEAL DIAPHRAGM 85 (<i>Diaphragm Wide Seal</i>)	T1	
WIDE-SEAL DIAPHRAGM 90 (<i>Diaphragm Wide Seal</i>)	T1	
WIDE-SEAL DIAPHRAGM 95 (<i>Diaphragm Wide Seal</i>)	T1	
Oxytocics		
Oxytocics		
<i>Methylergonovine Maleate Injection</i>	T1	
<i>Methylergonovine Maleate Oral</i>	T1	QL (28 EA per 7 days)
<i>miFEPRIStone Oral Tablet 200 MG</i>	T1	
<i>Oxytocin Injection</i>	T1	
Pharmaceutical Aids		
Pharmaceutical Aids		
<i>Bacteriostatic Water(Benz Alc)</i>	T1	
ELLIOTTS B (<i>Intrathecal Elec-Dextrose</i>)	T1	
<i>Emollient Base</i>	T1	
<i>Hydrogen Peroxide Solution 30 %</i>	T1	
PLURONIC F127 POWDER (<i>Poloxamer</i>)	T1	
<i>Sterile Water for Injection Injection</i>	T1	
Respiratory Tract Agents		
Alpha And Beta Adrenergic Agonist(Respr)		
<i>EPINEPHrine (Anaphylaxis)</i>	T1	
<i>EPINEPHrine Injection Solution 1 MG/ML</i>	T1	
<i>EPINEPHrine Injection Solution Auto-Injector 0.15 MG/0.3ML, 0.3 MG/0.3ML</i>	T1	QL (4 EA per 180 days)
<i>EPINEPHrine PF Injection Solution</i>	T1	
<i>Pseudoeph-Bromphen-DM Oral Syrup 30-2-10 MG/5ML</i>	T1	PA
Anticholinergic Agents (Respir.Tract)		

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Atropine Sulfate Injection Solution 8 MG/20ML</i>	T1	
<i>Atropine Sulfate Injection Solution Prefilled Syringe 0.25 MG/5ML, 0.5 MG/5ML, 1 MG/10ML</i>	T1	
<i>Atropine Sulfate Ophthalmic Solution 1 %</i>	T1	
ATROVENT HFA (<i>Ipratropium Bromide HFA</i>)	T1	
BREZTRI AEROSPHERE (<i>Budeson-Glycopyrrol-Formoterol</i>)	T1	PA
COMBIVENT RESPIMAT (<i>Ipratropium-Albuterol</i>)	T1	
<i>Diphenoxylate-Atropine Oral Liquid</i>	T1	
<i>Diphenoxylate-Atropine Oral Tablet 2.5-0.025 MG</i>	T1	
<i>Hyoscyamine Sulfate ER Oral Tablet Extended Release 12 Hour</i>	T1	
<i>Hyoscyamine Sulfate Oral</i>	T1	
<i>Hyoscyamine Sulfate Sublingual</i>	T1	
<i>Hyosyne</i>	T1	
INCRUSE ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5 MCG/ACT (<i>Umeclidinium Bromide</i>)	T1	QL (30 EA per 30 days)
<i>Ipratropium Bromide Inhalation</i>	T1	
<i>Ipratropium Bromide Nasal</i>	T1	
<i>Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML</i>	T1	
NULEV (<i>Hyoscyamine Sulfate</i>)	T1	
<i>Oscimin Oral Tablet</i>	T1	
<i>Oscimin Sublingual</i>	T1	
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 2.5 MCG/ACT (<i>Tiotropium Bromide</i>)	T1	QL (4 GM per 30 days)
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT (<i>Tiotropium Bromide-Olodaterol</i>)	T1	
<i>Tiotropium Bromide</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antifibrotic Agents		
OFEV (<i>Nintedanib Esylate</i>)	T1	PA
Anti-Inflammatory Agents (Respiratory)		
NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>Mepolizumab</i>)	T1	PA
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML (<i>Mepolizumab</i>)	T1	PA
NUCALA SUBCUTANEOUS SOLUTION RECONSTITUTED (<i>Mepolizumab</i>)	T1	PA
Antitussives		
<i>Benzonatate Oral Capsule 100 MG, 200 MG</i>	T1	
<i>Codeine Sulfate Oral Tablet</i>	T1	
<i>diphenhydrAMINE HCl Oral Capsule 25 MG</i>	T1	
<i>diphenhydrAMINE HCl Oral Elixir</i>	T1	
<i>Hydrocod Poli-Chlorphe Poli ER</i>	T1	QL (240 ML per 30 days); AL (Min 18 Years)
<i>HYDROcodone Bit-Homatrop MBr</i>	T1	QL (45 ML per 30 days); AL (Min 18 Years)
<i>Hydromet Oral Solution</i>	T1	QL (45 ML per 30 days); AL (Min 18 Years)
<i>Promethazine-Codeine</i>	T1	QL (240 ML per 30 days); AL (Min 18 Years)
<i>Promethazine-DM Oral Syrup 6.25-15 MG/5ML</i>	T1	
<i>Pseudoeph-Bromphen-DM Oral Syrup 30-2-10 MG/5ML</i>	T1	PA
Corticosteroids (Respiratory Tract)		
<i>Budesonide Inhalation Suspension 0.25 MG/2ML, 0.5 MG/2ML</i>	T1	QL (120 ML per 30 days)
<i>Budesonide Inhalation Suspension 1 MG/2ML</i>	T1	QL (60 ML per 30 days)
<i>Flunisolide Nasal Solution 25 MCG/ACT (0.025%)</i>	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Fluticasone Furoate Ellipta</i>	T1	
<i>Fluticasone Furoate-Vilanterol Inhalation Aerosol Powder Breath Activated 100-25 MCG/ACT, 200-25 MCG/ACT</i>	T1	
<i>Fluticasone Propionate Diskus</i>	T1	
<i>Fluticasone Propionate HFA</i>	T1	
<i>Fluticasone Propionate Nasal</i>	T1	
<i>Fluticasone-Salmeterol Inhalation Aerosol</i>	T1	PA
<i>Fluticasone-Salmeterol Inhalation Aerosol Powder Breath Activated 100-50 MCG/ACT, 113-14 MCG/ACT, 232-14 MCG/ACT, 250-50 MCG/ACT, 500-50 MCG/ACT, 55-14 MCG/ACT</i>	T1	
<i>Mometasone Furoate External</i>	T1	
PULMICORT FLEXHALER (<i>Budesonide</i>)	T1	
QVAR REDHALER (<i>Beclomethasone Diprop HFA</i>)	T1	
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT (<i>Fluticasone-Umeclidin-Vilant</i>)	T1	PA
<i>Fluticasone-Salmeterol</i> (Wixela Inhub Inhalation Aerosol Powder Breath Activated 100-50 Mcg/Act, 250-50 Mcg/Act, 500-50 Mcg/Act)	T1	
Endothelin Receptor Antagonists (48:48)		
<i>Ambrisentan</i>	T1	PA
<i>Bosentan Oral Tablet</i>	T1	PA
OPSUMIT (<i>Macitentan</i>)	T1	PA
TRACLEER ORAL TABLET SOLUBLE (<i>Bosentan</i>)	T1	PA
Expectorants		
<i>Iodine Strong Oral</i>	T1	
<i>Potassium Iodide (Expectorant)</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
First Generation Antihist.(Respir Tract)		
<i>Carbinoxamine Maleate Oral Solution</i>	T1	
<i>Carbinoxamine Maleate Oral Tablet 4 MG</i>	T1	
<i>Clemastine Fumarate Oral Syrup</i>	T1	
<i>Clemastine Fumarate Oral Tablet 2.68 MG</i>	T1	
<i>Cyproheptadine HCl Oral</i>	T1	
<i>diphenhydrAMINE HCl Oral Capsule 25 MG</i>	T1	
<i>diphenhydrAMINE HCl Oral Elixir</i>	T1	
<i>Promethazine HCl Oral Solution 6.25 MG/5ML</i>	T1	
<i>Promethazine HCl Oral Tablet</i>	T1	
<i>Promethazine HCl Rectal Suppository 12.5 MG, 25 MG</i>	T1	
<i>Promethazine-Codeine</i>	T1	QL (240 ML per 30 days); AL (Min 18 Years)
<i>Promethazine-DM Oral Syrup 6.25-15 MG/5ML</i>	T1	
PROMETHEGAN (<i>Promethazine HCl</i>)	T1	
<i>Pseudoeph-Bromphen-DM Oral Syrup 30-2-10 MG/5ML</i>	T1	PA
Interleukin Antagonists		
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML, 300 MG/2ML (<i>Dupilumab</i>)	T1	PA
FASENRA (<i>Benralizumab</i>)	T1	PA
FASENRA PEN (<i>Benralizumab</i>)	T1	PA
NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>Mepolizumab</i>)	T1	PA
NUCALA SUBCUTANEOUS SOLUTION RECONSTITUTED (<i>Mepolizumab</i>)	T1	PA
TEZSPIRE (<i>Tezepelumab-ekko</i>)	T1	PA
Leukotriene Modifiers		
<i>Montelukast Sodium Oral Packet</i>	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Montelukast Sodium Oral Tablet</i>	T1	
<i>Montelukast Sodium Oral Tablet Chewable</i>	T1	
<i>Zafirlukast</i>	T1	PA
Mast-Cell Stabilizers		
ALOCRIAL (<i>Nedocromil Sodium</i>)	T1	
<i>Cromolyn Sodium Inhalation</i>	T1	
<i>Cromolyn Sodium Ophthalmic</i>	T1	
<i>Cromolyn Sodium Oral</i>	T1	
Mucolytic Agents		
<i>Acetylcysteine Inhalation</i>	T1	
NEBUSAL INHALATION NEBULIZATION SOLUTION 3 % (<i>Sodium Chloride</i>)	T1	
PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML (<i>Dornase Alfa</i>)	T1	PA
<i>Sodium Chloride Inhalation Nebulization Solution 0.9 %, 10 %, 3 %</i>	T1	
Nasal Preparations (Steroids)		
<i>Flunisolide Nasal Solution 25 MCG/ACT (0.025%)</i>	T1	PA
<i>Fluticasone Propionate Nasal</i>	T1	
Orally Inhaled Preparations (Steroids)		
ASMANEX HFA (<i>Mometasone Furoate</i>)	T1	
BREZTRI AEROSPHERE (<i>Budeson-Glycopyrrol-Formoterol</i>)	T1	PA
<i>Budesonide Inhalation Suspension 0.25 MG/2ML, 0.5 MG/2ML</i>	T1	QL (120 ML per 30 days)
<i>Budesonide Inhalation Suspension 1 MG/2ML</i>	T1	QL (60 ML per 30 days)
<i>Budesonide-Formoterol Fumarate</i>	T1	QL (20.4 GM per 30 days)
DULERA (<i>Mometasone Furo-Formoterol Fum</i>)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Fluticasone Furoate Ellipta</i>	T1	
<i>Fluticasone Propionate Diskus</i>	T1	
<i>Fluticasone Propionate HFA</i>	T1	
<i>Fluticasone-Salmeterol Inhalation Aerosol Powder Breath Activated 113-14 MCG/ACT, 232-14 MCG/ACT, 55-14 MCG/ACT</i>	T1	
PULMICORT FLEXHALER (<i>Budesonide</i>)	T1	
QVAR REDHALER (<i>Beclomethasone Diprop HFA</i>)	T1	
Phosphodiesterase-5 Inhibitors (Respir)		
<i>Sildenafil Citrate Oral Tablet 20 MG</i>	T1	PA
<i>Tadalafil (PAH)</i>	T1	PA
Prostacyclin & Prostacyclin Derivatives		
ORENITRAM (<i>Treprostinil Diolamine</i>)	T1	PA
<i>Treprostinil</i>	T1	PA
TYVASO (<i>Treprostinil</i>)	T1	PA
TYVASO REFILL KIT (<i>Treprostinil</i>)	T1	PA
TYVASO STARTER KIT (<i>Treprostinil</i>)	T1	PA
Pulmonary Surfactants		
CUROSURF INTRATRACHEAL SUSPENSION 120 MG/1.5ML, 240 MG/3ML (<i>Poractant Alfa</i>)	T1	
INFASURF INTRATRACHEAL (<i>Calfactant in NaCl</i>)	T1	
Respiratory Tract Agents, Miscellaneous		
OFEV (<i>Nintedanib Esylate</i>)	T1	PA
TEZSPIRE (<i>Tezepelumab-ekko</i>)	T1	PA
XOLAIR (<i>Omalizumab</i>)	T1	PA
Second Generation Antihist(Respir Tract)		
<i>All Day Allergy Childrens Oral Solution 5 MG/5ML</i>	T1	
<i>All-Day Allergy Childrens</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Allergy Childrens Oral Solution</i>	T1	
<i>Allergy Childrens Oral Suspension</i>	T1	ST
<i>Allergy Rel Child (Loratadine)</i>	T1	
<i>Allergy Relief Childrens Oral Solution 1 MG/ML</i>	T1	
<i>Allergy Relief Oral Tablet 5 MG</i>	T1	
<i>Azelastine HCl Nasal Solution 0.1 %, 137 MCG/SPRAY</i>	T1	
<i>Azelastine HCl Ophthalmic</i>	T1	QL (6 ML per 30 days)
<i>Cetirizine HCl Allergy Child</i>	T1	
<i>Cetirizine HCl Childrens Alrgy Oral Solution</i>	T1	
<i>Cetirizine HCl Oral Solution 1 MG/ML</i>	T1	
<i>Cetirizine HCl Oral Tablet Chewable</i>	T1	
<i>Childrens 24 Hour Allergy</i>	T1	
<i>Childrens Loratadine Oral Solution</i>	T1	
<i>CVS Allergy Childrens Oral Solution</i>	T1	
<i>CVS Allergy Relief Childrens Oral Solution</i>	T1	
<i>CVS Allergy Relief Childrens Oral Suspension</i>	T1	ST
<i>CVS Allergy Relief Oral Tablet 5 MG</i>	T1	
<i>CVS Allergy Relief(Cetirizine)</i>	T1	
<i>Desloratadine Oral Tablet</i>	T1	PA
<i>Desloratadine Oral Tablet Dispersible 5 MG</i>	T1	PA
<i>EQ Allerg Relief Child (Cetir)</i>	T1	
<i>EQ Allerg Relief Child (Lorat)</i>	T1	
<i>EQ Allergy Childrens Oral Solution</i>	T1	
<i>EQ Allergy Relief (Cetirizine) Oral Solution</i>	T1	
<i>EQ Cetirizine HCl Oral Solution</i>	T1	
<i>EQL All Day Allergy Childrens</i>	T1	
<i>GNP All Day Allergy Childrens Oral Solution</i>	T1	
<i>GNP Allergy Relief 24 HR</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GNP Loratadine Childrens Oral Solution	T1	
GNP Loratadine Oral Solution	T1	
GoodSense All Day Allergy Oral Solution	T1	
KLS ALLER-TEC CHILDRENS ORAL SOLUTION 5 MG/5ML (Cetirizine HCl)	T1	
Levocetirizine Dihydrochloride Oral Tablet	T1	
Loratadine Childrens Oral Solution	T1	
Loratadine Oral Solution	T1	
QC All Day Allergy	T1	
WAL-ITIN CHILDRENS (Loratadine)	T1	
WAL-ITIN ORAL SOLUTION (Loratadine)	T1	
WAL-ZYR ALL DAY ALLERGY CHILD (Cetirizine HCl)	T1	
WAL-ZYR ALLERGY CHILDRENS (Cetirizine HCl)	T1	
WAL-ZYR CHILDRENS ORAL SOLUTION (Cetirizine HCl)	T1	
WAL-ZYR CHILDRENS ORAL TABLET CHEWABLE 10 MG (Cetirizine HCl)	T1	
Select.Beta-2-Adrenergic Agonist(Respir)		
Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT	T1	QL (36 GM per 30 days)
Albuterol Sulfate Inhalation Nebulization Solution (2.5 MG/3ML) 0.083%, (5 MG/ML) 0.5%, 2.5 MG/0.5ML	T1	
Albuterol Sulfate Inhalation Nebulization Solution 0.63 MG/3ML, 1.25 MG/3ML	T1	PA
Albuterol Sulfate Oral Syrup 2 MG/5ML	T1	
Albuterol Sulfate Oral Tablet	T1	
BREZTRI AEROSPHERE (Budeson-Glycopyrrol-Formoterol)	T1	PA
Budesonide-Formoterol Fumarate	T1	QL (20.4 GM per 30 days)
COMBIVENT RESPIMAT (Ipratropium-Albuterol)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DULERA (<i>Mometasone Furo-Formoterol Fum</i>)	T1	
<i>Fluticasone-Salmeterol Inhalation Aerosol Powder Breath Activated 113-14 MCG/ACT, 232-14 MCG/ACT, 55-14 MCG/ACT</i>	T1	
<i>Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML</i>	T1	
<i>Levalbuterol HCl Inhalation Nebulization Solution 0.31 MG/3ML, 0.63 MG/3ML, 1.25 MG/0.5ML, 1.25 MG/3ML</i>	T1	PA
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (<i>Salmeterol Xinafoate</i>)	T1	
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT (<i>Tiotropium Bromide-Olodaterol</i>)	T1	
<i>Terbutaline Sulfate Oral</i>	T1	
Vasodilating Agents (Respiratory Tract)		
ADEMPAS (<i>Riociguat</i>)	T1	PA
<i>Ambrisentan</i>	T1	PA
<i>Bosentan Oral Tablet</i>	T1	PA
OPSUMIT (<i>Macitentan</i>)	T1	PA
ORENITRAM (<i>Treprostinil Diolamine</i>)	T1	PA
<i>Sildenafil Citrate Oral Tablet 20 MG</i>	T1	PA
<i>Tadalafil (PAH)</i>	T1	PA
TRACLEER ORAL TABLET SOLUBLE (<i>Bosentan</i>)	T1	PA
<i>Treprostinil</i>	T1	PA
TYVASO (<i>Treprostinil</i>)	T1	PA
TYVASO REFILL KIT (<i>Treprostinil</i>)	T1	PA
TYVASO STARTER KIT (<i>Treprostinil</i>)	T1	PA
UPTRAVI ORAL (<i>Selexipag</i>)	T1	PA
UPTRAVI TITRATION (<i>Selexipag</i>)	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Vasodilating Agents, Misc (48:48)		
ADEMPAS (<i>Riociguat</i>)	T1	PA
UPTRAVI ORAL (<i>Selexipag</i>)	T1	PA
UPTRAVI TITRATION (<i>Selexipag</i>)	T1	PA
Xanthine Derivatives		
THEO-24 (<i>Theophylline</i>)	T1	
<i>Theophylline ER Oral Tablet Extended Release 12 Hour 300 MG, 450 MG</i>	T1	
<i>Theophylline ER Oral Tablet Extended Release 24 Hour</i>	T1	
<i>Theophylline Oral Elixir</i>	T1	
Skin And Mucous Membrane Agents		
Adrenergic Agonists		
<i>Brimonidine Tartrate Ophthalmic Solution 0.15 %</i>	T1	PA
<i>Brimonidine Tartrate Ophthalmic Solution 0.2 %</i>	T1	
<i>Brimonidine Tartrate-Timolol</i>	T1	PA
Allylamines (Skin And Mucous Membrane)		
<i>Athletes Foot (Terbinafine)</i>	T1	
<i>CVS Athletes Foot External Cream</i>	T1	
<i>CVS Jock Itch</i>	T1	
<i>EQ Athletes Foot (Terbinafine)</i>	T1	
<i>GNP Terbinafine Hydrochloride</i>	T1	
LAMISIL AT ATHLETES FOOT (<i>Terbinafine HCl</i>)	T1	
<i>Naftifine HCl External Cream 1 %</i>	T1	
<i>Terbinafine HCl External</i>	T1	
Antibacterials (84:04)		
AVAR-E EMOLLIENT (<i>Sulfacetamide Sodium-Sulfur</i>)	T1	
<i>Avidoxy</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Azelaic Acid External</i>	T1	PA
<i>Bacitracin Ophthalmic</i>	T1	
<i>Bacitracin-Polymyxin B Ophthalmic Ointment 500-10000 UNIT/GM</i>	T1	
<i>Bacitra-Neomycin-Polymyxin-HC</i>	T1	
CLEOCIN VAGINAL SUPPOSITORY (<i>Clindamycin Phosphate</i>)	T1	ST
<i>Clindamycin Phosphate</i> (Clindacin Etz External Swab)	T1	
<i>Clindamycin Phosphate</i> (Clindacin-P)	T1	
<i>Clindamycin HCl Oral</i>	T1	
<i>Clindamycin Phos (Once-Daily)</i>	T1	
<i>Clindamycin Phos (Twice-Daily)</i>	T1	
<i>Clindamycin Phos-Benzoyl Perox External Gel 1-5 %</i>	T1	PA
<i>Clindamycin Phosphate External Lotion</i>	T1	
<i>Clindamycin Phosphate External Solution</i>	T1	
<i>Clindamycin Phosphate External Swab</i>	T1	
<i>Clindamycin Phosphate Vaginal</i>	T1	
<i>Dapsone Oral</i>	T1	
<i>Doxycycline Hyclate</i> (Doxy 100)	T1	
<i>Doxycycline Hyclate Oral Capsule</i>	T1	
<i>Doxycycline Hyclate Oral Tablet 100 MG</i>	T1	
<i>Doxycycline Hyclate Oral Tablet 20 MG</i>	T1	PA
<i>Doxycycline Monohydrate Oral Capsule 100 MG, 50 MG</i>	T1	
<i>Doxycycline Monohydrate Oral Suspension Reconstituted</i>	T1	
<i>Doxycycline Monohydrate Oral Tablet 100 MG, 50 MG, 75 MG</i>	T1	
<i>EQL Bacitracin Zinc</i>	T1	
<i>Ery</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Erythromycin External Gel</i>	T1	
<i>Erythromycin External Solution</i>	T1	
FINACEA EXTERNAL FOAM (<i>Azelaic Acid</i>)	T1	PA
<i>Gentamicin Sulfate External</i>	T1	
<i>Gentamicin Sulfate Ophthalmic Solution</i>	T1	
<i>levoFLOXacin Oral Solution</i>	T1	
<i>levoFLOXacin Oral Tablet</i>	T1	QL (30 EA per 30 days)
<i>metroNIDAZOLE External Cream</i>	T1	QL (45 GM per 30 days)
<i>metroNIDAZOLE External Gel 0.75 %</i>	T1	QL (45 GM per 30 days)
<i>metroNIDAZOLE External Gel 1 %</i>	T1	QL (60 GM per 30 days)
<i>metroNIDAZOLE Oral Capsule</i>	T1	
<i>metroNIDAZOLE Oral Tablet 250 MG, 500 MG</i>	T1	
<i>metroNIDAZOLE Vaginal</i>	T1	
<i>Minocycline HCl Oral Capsule 100 MG</i>	T1	QL (60 EA per 30 days)
<i>Minocycline HCl Oral Capsule 50 MG</i>	T1	
<i>Doxycycline Monohydrate</i> (Mondoxyne NI Oral Capsule 100 Mg)	T1	
<i>Moxifloxacin HCl Oral</i>	T1	QL (21 EA per 21 days)
<i>Mupirocin External</i>	T1	
<i>Neomycin Sulfate Oral</i>	T1	
NORITATE (<i>MetroNIDAZOLE</i>)	T1	PA
<i>Polymyxin B-Trimethoprim</i>	T1	
<i>Sodium Sulfacetamide External Shampoo 10 %</i>	T1	
<i>SSS 10-5 External Cream</i>	T1	
<i>Sulfacetamide Sodium-Sulfur External Cream 10-5 %</i>	T1	
<i>Sulfacetamide Sodium-Sulfur External Lotion 10-5 %</i>	T1	
<i>Sulfacetamide Sodium-Sulfur External Suspension 10-5 %</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Sulfacetamide-Sulfur in Urea External Emulsion</i>	T1	
SULFAMYLON EXTERNAL CREAM (<i>Mafenide Acetate</i>)	T1	PA
<i>Tetracycline HCl Oral Capsule</i>	T1	
Antifulgals (Skin, Mucous Membrane), Misc		
EXODERM EXTERNAL LOTION (<i>Sod Thiosulfate-Salicylic Acd</i>)	T1	
Anti-Inflammatory Agents (Skin, Mucous)		
<i>Ala-Cort External Cream 1 %</i>	T1	
<i>Alclometasone Dipropionate</i>	T1	PA
<i>Anucort-HC</i>	T1	
ANUSOL-HC EXTERNAL (<i>Hydrocortisone</i>)	T1	
<i>Betamethasone Dipropionate Aug External Cream</i>	T1	
<i>Betamethasone Dipropionate Aug External Gel</i>	T1	
<i>Betamethasone Dipropionate Aug External Lotion</i>	T1	PA
<i>Betamethasone Dipropionate Aug External Ointment</i>	T1	PA
<i>Betamethasone Dipropionate External</i>	T1	
<i>Betamethasone Valerate External Cream</i>	T1	
<i>Betamethasone Valerate External Foam</i>	T1	PA
<i>Betamethasone Valerate External Lotion</i>	T1	
<i>Betamethasone Valerate External Ointment</i>	T1	
<i>Calcipotriene-Betameth Diprop External Suspension</i>	T1	PA
<i>Clobetasol Prop Emollient Base</i>	T1	
<i>Clobetasol Propionate E</i>	T1	
<i>Clobetasol Propionate External Cream 0.05 %</i>	T1	
<i>Clobetasol Propionate External Foam</i>	T1	
<i>Clobetasol Propionate External Gel</i>	T1	
<i>Clobetasol Propionate External Lotion</i>	T1	
<i>Clobetasol Propionate External Ointment</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Clobetasol Propionate External Shampoo</i>	T1	PA
<i>Clobetasol Propionate External Solution</i>	T1	
<i>Clocortolone Pivalate</i>	T1	PA
<i>Clobetasol Propionate</i> (Clodan External Shampoo)	T1	PA
<i>Clotrimazole-Betamethasone</i>	T1	
CORDRAN EXTERNAL TAPE (<i>Flurandrenolide</i>)	T1	PA
CORTIFOAM EXTERNAL (<i>Hydrocortisone Acetate</i>)	T1	PA
<i>Desonide External Cream</i>	T1	
<i>Desonide External Lotion</i>	T1	PA
<i>Desonide External Ointment</i>	T1	
<i>Desoximetasone External Cream</i>	T1	PA
<i>Desoximetasone External Gel</i>	T1	PA
<i>Desoximetasone External Ointment 0.25 %</i>	T1	PA
<i>Diflorasone Diacetate External</i>	T1	PA
EPIFOAM (<i>Pramoxine-HC</i>)	T1	PA
<i>Fluocinolone Acetonide Body</i>	T1	
<i>Fluocinolone Acetonide External</i>	T1	
<i>Fluocinolone Acetonide Scalp</i>	T1	
<i>Fluocinonide Emulsified Base</i>	T1	
<i>Fluocinonide External</i>	T1	
<i>Flurandrenolide External Lotion</i>	T1	PA
<i>Fluticasone Propionate External Cream</i>	T1	
<i>Fluticasone Propionate External Ointment</i>	T1	
<i>Halcinonide External Cream</i>	T1	PA
<i>Halobetasol Propionate External Cream</i>	T1	
<i>Halobetasol Propionate External Ointment</i>	T1	
HALOG EXTERNAL SOLUTION (<i>Halcinonide</i>)	T1	PA
<i>Hydrocortisone (Perianal)</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Hydrocortisone Ace-Pramoxine External Cream 1-1 %, 2.5-1 %</i>	T1	
<i>Hydrocortisone Acetate Rectal</i>	T1	
<i>Hydrocortisone Butyrate External Cream</i>	T1	PA
<i>Hydrocortisone Butyrate External Ointment</i>	T1	PA
<i>Hydrocortisone Butyrate External Solution</i>	T1	PA
<i>Hydrocortisone External Cream 1 %, 2.5 %</i>	T1	
<i>Hydrocortisone External Lotion 2.5 %</i>	T1	
<i>Hydrocortisone External Ointment 1 %, 2.5 %</i>	T1	
<i>Hydrocortisone Rectal Enema</i>	T1	
<i>Hydrocortisone Valerate</i>	T1	PA
<i>Hydrocort-Pramoxine (Perianal)</i>	T1	
<i>Lidocaine-Hydrocort (Perianal)</i>	T1	
<i>Lidocaine-Hydrocortisone Ace Rectal Kit 3-0.5 %</i>	T1	
LIDOCORT EXTERNAL (<i>Lidocaine-Hydrocortisone Ace</i>)	T1	
<i>Mometasone Furoate External</i>	T1	
<i>Triamcinolone Acetonide</i> (Oralone)	T1	
PRAMOSONE EXTERNAL CREAM 1-1 % (<i>Pramoxine-HC</i>)	T1	
PRAMOSONE EXTERNAL LOTION (<i>Pramoxine-HC</i>)	T1	PA
PRAMOSONE EXTERNAL OINTMENT (<i>Pramoxine-HC</i>)	T1	
PROCTOFOAM HC EXTERNAL (<i>Hydrocortisone Ace-Pramoxine</i>)	T1	PA
<i>Hydrocortisone</i> (Procto-Med Hc External)	T1	
<i>Hydrocortisone</i> (Proctosol Hc External)	T1	
<i>Hydrocortisone</i> (Proctozone-Hc External)	T1	
TEXACORT (<i>Hydrocortisone</i>)	T1	
<i>Triamcinolone Acetonide External Aerosol Solution</i>	T1	PA

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bold italics = Generic drugs UPPERCASE = Brand name drugs	Drug Tier	Coverage Requirements and Limits
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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Triamcinolone Acetonide External Cream</i>	T1	
<i>Triamcinolone Acetonide External Lotion</i>	T1	
<i>Triamcinolone Acetonide External Ointment 0.025 %, 0.1 %, 0.5 %</i>	T1	
<i>Triamcinolone Acetonide External Ointment 0.05 %</i>	T1	PA
<i>Triamcinolone Acetonide Mouth/Throat</i>	T1	
<i>Triamcinolone in Absorbase</i>	T1	PA
<i>Triamcinolone Acetonide</i> (Triderm External Cream 0.5 %)	T1	
Antiproliferants		
<i>Bexarotene Oral</i>	T1	PA
<i>Fluorouracil External Cream 5 %</i>	T1	
<i>Fluorouracil External Solution</i>	T1	
<i>Imiquimod External Cream 5 %</i>	T1	
Antipruritics And Local Anesthetics		
CETACAINE EXTERNAL AEROSOL (<i>Butamben-Tetracaine-Benzocaine</i>)	T1	
CORTANE-B EXTERNAL (<i>HC-Pramoxine-Chloroxylonol</i>)	T1	
CRYODOSE TA (<i>Pentafluoroprop-Tetrafluoroeth</i>)	T1	
<i>CVS Itch Relief External Gel</i>	T1	
<i>Doxepin HCl External</i>	T1	
<i>Doxepin HCl Oral Capsule</i>	T1	
<i>Doxepin HCl Oral Concentrate</i>	T1	
<i>Doxepin HCl Oral Tablet</i>	T1	PA
EPIFOAM (<i>Pramoxine-HC</i>)	T1	PA
<i>Ethyl Chloride</i>	T1	
GEBAUERS PAIN EASE (<i>Pentafluoroprop-Tetrafluoroeth</i>)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GEBAUERS SPRAY AND STRETCH (<i>Pentafluoroprop-Tetrafluoroeth</i>)	T1	
<i>Lidocaine HCl</i> (Glydo External Prefilled Syringe)	T1	
<i>Hydrocortisone Ace-Pramoxine External Cream 1-1 %, 2.5-1 %</i>	T1	
<i>Hydrocort-Pramoxine (Perianal)</i>	T1	
<i>Lidocaine External Ointment 5 %</i>	T1	QL (60 GM per 30 days)
<i>Lidocaine External Patch 5 %</i>	T1	PA
<i>Lidocaine HCl External Cream 3 %</i>	T1	
<i>Lidocaine HCl External Solution</i>	T1	PA
<i>Lidocaine HCl Urethral/Mucosal External Prefilled Syringe</i>	T1	
<i>Lidocaine-Hydrocort (Perianal)</i>	T1	
<i>Lidocaine-Hydrocortisone Ace Rectal Kit 3-0.5 %</i>	T1	
<i>Lidocaine-Prilocaine External Cream</i>	T1	QL (60 GM per 30 days)
LIDOCORT EXTERNAL (<i>Lidocaine-Hydrocortisone Ace</i>)	T1	
<i>Lidopin External Cream 3 %</i>	T1	QL (85 GM per 30 days)
<i>Phenazopyridine HCl Oral Tablet 100 MG, 200 MG</i>	T1	
PRAMOSONE EXTERNAL CREAM 1-1 % (<i>Pramoxine-HC</i>)	T1	
PRAMOSONE EXTERNAL LOTION (<i>Pramoxine-HC</i>)	T1	PA
PRAMOSONE EXTERNAL OINTMENT (<i>Pramoxine-HC</i>)	T1	
PROCTOFOAM HC EXTERNAL (<i>Hydrocortisone Ace-Pramoxine</i>)	T1	PA
REGENECARE (<i>Lidocaine-Collagen-Aloe Vera</i>)	T1	
<i>Zionodil</i>	T1	
Antivirals (Skin And Mucous Membrane)		
<i>Acyclovir External</i>	T1	PA
<i>Acyclovir Oral Capsule</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Acyclovir Oral Suspension 200 MG/5ML</i>	T1	
<i>Acyclovir Oral Tablet</i>	T1	
Astringents (84:12)		
<i>DRYSOL (Aluminum Chloride)</i>	T1	
<i>Glycopyrrolate Oral Tablet 1 MG, 2 MG</i>	T1	
<i>XERAC AC (Aluminum Chloride in Alcohol)</i>	T1	
Astringents, Anti-Infective		
<i>Benzalkonium Chloride External Solution , 50 %</i>	T1	
<i>Chlorhexidine Gluconate Mouth/Throat</i>	T1	
<i>Hydrocortisone-Iodoquinol External Cream 1-1 %</i>	T1	
<i>Iodine Strong Oral</i>	T1	
<i>IODOFLEX (Cadexomer Iodine)</i>	T1	
<i>Chlorhexidine Gluconate (Periogard)</i>	T1	
<i>Selenium Sulfide External Lotion</i>	T1	
<i>Selenium Sulfide External Shampoo 2.25 %</i>	T1	
<i>Silver sulfADIAZINE External</i>	T1	
Azoles (Skin And Mucous Membrane)		
<i>Clotrimazole External Cream</i>	T1	
<i>Clotrimazole External Solution</i>	T1	
<i>Clotrimazole Mouth/Throat Troche</i>	T1	
<i>Clotrimazole-Betamethasone</i>	T1	
<i>Econazole Nitrate External Cream</i>	T1	
<i>GYNAZOLE-1 (Butoconazole Nitrate (1 Dose))</i>	T1	
<i>Ketoconazole External Cream</i>	T1	
<i>Ketoconazole External Shampoo 2 %</i>	T1	
<i>Miconazole 3 Vaginal Suppository</i>	T1	
<i>Miconazole Nitrate External Cream</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Terconazole Vaginal Cream</i>	T1	
<i>Terconazole Vaginal Suppository</i>	T1	PA
Basic Ointments And Protectants		
<i>Calcipotriene External</i>	T1	PA
<i>Calcipotriene-Betameth Diprop External Suspension</i>	T1	PA
<i>Emollient Base</i>	T1	
<i>Hydrocortisone External Cream 1 %</i>	T1	
REGENECARE (<i>Lidocaine-Collagen-Aloe Vera</i>)	T1	
SANTYL (<i>Collagenase</i>)	T1	
Cell Stimulants And Proliferants		
<i>Finasteride Oral Tablet 5 MG</i>	T1	
<i>Minoxidil Oral</i>	T1	
<i>Tretinoin External Cream</i>	T1	QL (50 GM per 30 days); AL (Max 29 Years)
<i>Tretinoin External Gel 0.01 %, 0.025 %</i>	T1	QL (50 GM per 30 days); AL (Max 29 Years)
<i>Tretinoin Microsphere External Gel 0.04 %, 0.1 %</i>	T1	QL (50 GM per 30 days); AL (Max 29 Years)
<i>Tretinoin Microsphere Pump External Gel 0.04 %, 0.1 %</i>	T1	QL (50 GM per 30 days); AL (Max 29 Years)
<i>Tretinoin Oral</i>	T1	PA
Corticosteroids (Skin, Mucous Membrane)		
<i>Ala-Cort External Cream 1 %</i>	T1	
<i>Alclometasone Dipropionate</i>	T1	PA
<i>Anucort-HC</i>	T1	
ANUSOL-HC EXTERNAL (<i>Hydrocortisone</i>)	T1	
<i>Betamethasone Dipropionate Aug External Cream</i>	T1	
<i>Betamethasone Dipropionate Aug External Gel</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Betamethasone Dipropionate Aug External Lotion</i>	T1	PA
<i>Betamethasone Dipropionate Aug External Ointment</i>	T1	PA
<i>Betamethasone Dipropionate External</i>	T1	
<i>Betamethasone Valerate External Cream</i>	T1	
<i>Betamethasone Valerate External Foam</i>	T1	PA
<i>Betamethasone Valerate External Lotion</i>	T1	
<i>Betamethasone Valerate External Ointment</i>	T1	
<i>Budesonide Rectal Foam 2 MG</i>	T1	PA
<i>Calcipotriene-Betameth Diprop External Suspension</i>	T1	PA
<i>Clobetasol Prop Emollient Base</i>	T1	
<i>Clobetasol Propionate E</i>	T1	
<i>Clobetasol Propionate External Cream 0.05 %</i>	T1	
<i>Clobetasol Propionate External Foam</i>	T1	
<i>Clobetasol Propionate External Gel</i>	T1	
<i>Clobetasol Propionate External Lotion</i>	T1	
<i>Clobetasol Propionate External Ointment</i>	T1	
<i>Clobetasol Propionate External Shampoo</i>	T1	PA
<i>Clobetasol Propionate External Solution</i>	T1	
<i>Clocortolone Pivalate</i>	T1	PA
<i>Clobetasol Propionate</i> (Clodan External Shampoo)	T1	PA
<i>Clotrimazole-Betamethasone</i>	T1	
CORDRAN EXTERNAL TAPE (<i>Flurandrenolide</i>)	T1	PA
CORTANE-B EXTERNAL (<i>HC-Pramoxine-Chloroxylonol</i>)	T1	
CORTIFOAM EXTERNAL (<i>Hydrocortisone Acetate</i>)	T1	PA
<i>Desonide External Cream</i>	T1	
<i>Desonide External Lotion</i>	T1	PA
<i>Desonide External Ointment</i>	T1	
<i>Desoximetasone External Cream</i>	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Desoximetasone External Gel</i>	T1	PA
<i>Desoximetasone External Ointment 0.25 %</i>	T1	PA
<i>Diflorasone Diacetate External</i>	T1	PA
EPIFOAM (<i>Pramoxine-HC</i>)	T1	PA
<i>Fluocinolone Acetonide Body</i>	T1	
<i>Fluocinolone Acetonide External</i>	T1	
<i>Fluocinolone Acetonide Scalp</i>	T1	
<i>Fluocinonide Emulsified Base</i>	T1	
<i>Fluocinonide External</i>	T1	
<i>Flurandrenolide External Lotion</i>	T1	PA
<i>Fluticasone Propionate External Cream</i>	T1	
<i>Fluticasone Propionate External Ointment</i>	T1	
<i>Halcinonide External Cream</i>	T1	PA
<i>Halobetasol Propionate External Cream</i>	T1	
<i>Halobetasol Propionate External Ointment</i>	T1	
HALOG EXTERNAL SOLUTION (<i>Halcinonide</i>)	T1	PA
<i>Hydrocortisone (Perianal)</i>	T1	
<i>Hydrocortisone Ace-Pramoxine External Cream 1-1 %, 2.5-1 %</i>	T1	
<i>Hydrocortisone Acetate Rectal</i>	T1	
<i>Hydrocortisone Butyrate External Cream</i>	T1	PA
<i>Hydrocortisone Butyrate External Ointment</i>	T1	PA
<i>Hydrocortisone Butyrate External Solution</i>	T1	PA
<i>Hydrocortisone External Cream 1 %, 2.5 %</i>	T1	
<i>Hydrocortisone External Lotion 2.5 %</i>	T1	
<i>Hydrocortisone External Ointment 1 %, 2.5 %</i>	T1	
<i>Hydrocortisone Oral</i>	T1	
<i>Hydrocortisone Rectal Enema</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Hydrocortisone Valerate</i>	T1	PA
<i>Hydrocortisone-Acetic Acid</i>	T1	
<i>Hydrocortisone-Iodoquinol External Cream 1-1 %</i>	T1	
<i>Hydrocort-Pramoxine (Perianal)</i>	T1	
<i>Lidocaine-Hydrocort (Perianal)</i>	T1	
<i>Lidocaine-Hydrocortisone Ace Rectal Kit 3-0.5 %</i>	T1	
LIDOCORT EXTERNAL (<i>Lidocaine-Hydrocortisone Ace</i>)	T1	
<i>Mometasone Furoate External</i>	T1	
<i>Nystatin-Triamcinolone</i>	T1	
<i>Triamcinolone Acetonide</i> (Oralone)	T1	
PRAMOSONE EXTERNAL CREAM 1-1 % (<i>Pramoxine-HC</i>)	T1	
PRAMOSONE EXTERNAL LOTION (<i>Pramoxine-HC</i>)	T1	PA
PRAMOSONE EXTERNAL OINTMENT (<i>Pramoxine-HC</i>)	T1	
PROCTOFOAM HC EXTERNAL (<i>Hydrocortisone Ace-Pramoxine</i>)	T1	PA
<i>Hydrocortisone</i> (Procto-Med Hc External)	T1	
<i>Hydrocortisone</i> (Proctosol Hc External)	T1	
<i>Hydrocortisone</i> (Proctozone-Hc External)	T1	
TEXACORT (<i>Hydrocortisone</i>)	T1	
<i>Triamcinolone Acetonide External Aerosol Solution</i>	T1	PA
<i>Triamcinolone Acetonide External Cream</i>	T1	
<i>Triamcinolone Acetonide External Lotion</i>	T1	
<i>Triamcinolone Acetonide External Ointment 0.025 %, 0.1 %, 0.5 %</i>	T1	
<i>Triamcinolone Acetonide External Ointment 0.05 %</i>	T1	PA
<i>Triamcinolone Acetonide Mouth/Throat</i>	T1	
<i>Triamcinolone in Absorbase</i>	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Triamcinolone Acetonide</i> (Triderm External Cream 0.5 %)	T1	
Detergents		
<i>Polysorbate 80</i>	T1	
Hydroxypyridones (Skin, Mucous Membrane)		
<i>Ciclopirox</i> (Ciclodan External Solution)	T1	
<i>Ciclopirox External</i>	T1	
<i>Ciclopirox Olamine External</i>	T1	
Immunomodulatory Agents (84:06)		
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>Dupilumab</i>)	T1	PA
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML, 300 MG/2ML (<i>Dupilumab</i>)	T1	PA
<i>Pimecrolimus</i>	T1	PA
PROGRAF ORAL CAPSULE (<i>Tacrolimus</i>)	T1	
SILIQ (<i>Brodalumab</i>)	T1	PA
<i>Sirolimus Oral</i>	T1	
<i>Tacrolimus External Ointment</i>	T1	QL (30 GM per 30 days)
<i>Tacrolimus Oral</i>	T1	
Janus Kinase Inhibitors (84:06)		
JAKAFI (<i>Ruxolitinib Phosphate</i>)	T1	PA
Keratolytic Agents		
<i>ISOTretinoin</i> (Accutane Oral Capsule 40 Mg)	T1	PA
<i>Acitretin Oral Capsule 10 MG, 25 MG</i>	T1	
<i>Adapalene External Gel 0.1 %</i>	T1	
<i>Adapalene External Pad</i>	T1	
<i>Adapalene External Solution</i>	T1	
<i>Adapalene-Benzoyl Peroxide External Gel 0.1-2.5 %</i>	T1	QL (45 GM per 30 days); AL (Max 30 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>ISOTretinoin</i> (Amnesteem)	T1	PA
AVAR-E EMOLLIENT (<i>Sulfacetamide Sodium-Sulfur</i>)	T1	
<i>Benzoyl Peroxide External Gel 10 %</i>	T1	
<i>Benzoyl Peroxide Wash External Liquid 10 %</i>	T1	
<i>ISOTretinoin</i> (Claravis)	T1	PA
<i>Clindamycin Phos-Benzoyl Perox External Gel 1-5 %</i>	T1	PA
CONDYLOX EXTERNAL GEL (<i>Podofilox</i>)	T1	QL (7 GM per 365 days)
EXODERM EXTERNAL LOTION (<i>Sod Thiosulfate-Salicylic Acd</i>)	T1	
<i>ISOTretinoin Oral Capsule 10 MG, 20 MG, 30 MG, 40 MG</i>	T1	PA
<i>Podofilox External Solution</i>	T1	
<i>Salicylic Acid External Shampoo</i>	T1	
<i>Selenium Sulfide External Shampoo 2.25 %</i>	T1	
<i>SSS 10-5 External Cream</i>	T1	
<i>Sulfacetamide Sodium-Sulfur External Cream 10-5 %</i>	T1	
<i>Sulfacetamide Sodium-Sulfur External Lotion 10-5 %</i>	T1	
<i>Sulfacetamide Sodium-Sulfur External Suspension 10-5 %</i>	T1	
<i>Sulfacetamide-Sulfur in Urea External Emulsion</i>	T1	
<i>Tazarotene External Cream</i>	T1	
<i>Tazarotene External Gel</i>	T1	
<i>ISOTretinoin</i> (Zenatane)	T1	PA
Keratoplastic Agents		
<i>Coal Tar External Solution</i>	T1	
<i>Coal Tar Solution</i>	T1	
Local Anti-Infectives, Miscellaneous		
<i>Acetic Acid Glacial Solution 99 %</i>	T1	
<i>Acetic Acid Solution 5 %</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Adapalene-Benzoyl Peroxide External Gel 0.1-2.5 %</i>	T1	QL (45 GM per 30 days); AL (Max 30 Years)
AVAR-E EMOLLIENT (<i>Sulfacetamide Sodium-Sulfur</i>)	T1	
<i>Benzalkonium Chloride External Solution , 50 %</i>	T1	
<i>Benzoyl Peroxide External Gel 10 %</i>	T1	
<i>Benzoyl Peroxide Wash External Liquid 10 %</i>	T1	
<i>Chlorhexidine Gluconate Mouth/Throat</i>	T1	
<i>Clindamycin Phos-Benzoyl Perox External Gel 1-5 %</i>	T1	PA
CORTANE-B EXTERNAL (<i>HC-Pramoxine-Chloroxylenol</i>)	T1	
DEBACTEROL (<i>Sulfuric Acid-Sulf Phenolics</i>)	T1	
FEM PH (<i>Acetic Acid-Oxyquinoline</i>)	T1	
<i>Hydrocortisone-Iodoquinol External Cream 1-1 %</i>	T1	
<i>Hydrogen Peroxide Solution 30 %</i>	T1	
IODOFLEX (<i>Cadexomer Iodine</i>)	T1	
<i>Chlorhexidine Gluconate</i> (Periogard)	T1	
<i>Selenium Sulfide External Lotion</i>	T1	
<i>Selenium Sulfide External Shampoo 2.25 %</i>	T1	
<i>Silver Nitrate External Solution 0.5 %</i>	T1	
<i>Silver sulfADIAZINE External</i>	T1	
<i>Sodium Sulfacetamide External Shampoo 10 %</i>	T1	
<i>SSS 10-5 External Cream</i>	T1	
<i>Sulfacetamide Sodium-Sulfur External Cream 10-5 %</i>	T1	
<i>Sulfacetamide Sodium-Sulfur External Lotion 10-5 %</i>	T1	
<i>Sulfacetamide Sodium-Sulfur External Suspension 10-5 %</i>	T1	
<i>Sulfacetamide-Sulfur in Urea External Emulsion</i>	T1	
SULFAMYLON EXTERNAL CREAM (<i>Mafenide Acetate</i>)	T1	PA
Nonsteroidal Anti-Inflammat.Agents(Skin)		

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bold italics = Generic drugs UPPERCASE = Brand name drugs	Drug Tier	Coverage Requirements and Limits
	SCO = State Carve Out T1 = Preferred Medication T2 = Preferred Medication with Restriction T3 = Non-Preferred Medication - Prior Authorization is Required	AL = Age Limit PA = Prior Authorization QL = Quantity Limit SCO = State Carve Out ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Diclofenac Epolamine External</i>	T1	PA
<i>Diclofenac Sodium External Gel 1 %</i>	T1	
Pigmenting Agents		
UVADEX EXTRACORPOREAL (<i>Methoxsalen (Photopheresis)</i>)	T1	
Polyenes (Skin And Mucous Membrane)		
<i>Nystatin</i> (Nyamyc)	T1	
<i>Nystatin External</i>	T1	
<i>Nystatin Mouth/Throat</i>	T1	
<i>Nystatin-Triamcinolone</i>	T1	
<i>Nystatin</i> (Nystop)	T1	
Scabicides And Pediculicides		
<i>Malathion External</i>	T1	PA
<i>Permethrin External Cream</i>	T1	
<i>Spinosad</i>	T1	PA
Skin And Mucous Membrane Agents, Misc.		
<i>ISOTretinoin</i> (Accutane Oral Capsule 40 Mg)	T1	PA
<i>Acitretin Oral Capsule 10 MG, 25 MG</i>	T1	
<i>Adapalene External Gel 0.1 %</i>	T1	
<i>Adapalene External Pad</i>	T1	
<i>Adapalene External Solution</i>	T1	
<i>Adapalene-Benzoyl Peroxide External Gel 0.1-2.5 %</i>	T1	QL (45 GM per 30 days); AL (Max 30 Years)
<i>ISOTretinoin</i> (Amnesteem)	T1	PA
AVSOLA (<i>inFLIXimab-axxq</i>)	T1	PA
<i>Azelaic Acid External</i>	T1	PA
<i>Calcipotriene External</i>	T1	PA
<i>Calcipotriene-Betameth Diprop External Suspension</i>	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Calcitriol External</i>	T1	PA
<i>ISOTretinoin</i> (Claravis)	T1	PA
CONDYLOX EXTERNAL GEL (<i>Podofilox</i>)	T1	QL (7 GM per 365 days)
<i>Dapsone Oral</i>	T1	
DEBACTEROL (<i>Sulfuric Acid-Sulf Phenolics</i>)	T1	
<i>Diclofenac Epolamine External</i>	T1	PA
<i>Diclofenac Sodium External Gel 1 %</i>	T1	
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>Dupilumab</i>)	T1	PA
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML, 300 MG/2ML (<i>Dupilumab</i>)	T1	PA
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (<i>Etanercept</i>)	T1	PA
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>Etanercept</i>)	T1	PA
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>Etanercept</i>)	T1	PA
FEM PH (<i>Acetic Acid-Oxyquinoline</i>)	T1	
FINACEA EXTERNAL FOAM (<i>Azelaic Acid</i>)	T1	PA
<i>Fluorouracil External Cream 5 %</i>	T1	
<i>Fluorouracil External Solution</i>	T1	
GELCLAIR (<i>Povidone-NaHyaluron-Glycyrrhet</i>)	T1	
<i>Imiquimod External Cream 5 %</i>	T1	
INFLECTRA (<i>InFLIXimab-dyyb</i>)	T1	PA
<i>inFLIXimab</i>	T1	PA
<i>ISOTretinoin Oral Capsule 10 MG, 20 MG, 30 MG, 40 MG</i>	T1	PA
ORAMAGICRX (<i>Oral Wound Care Products</i>)	T1	
OTEZLA ORAL TABLET (<i>Apremilast</i>)	T1	PA
OTEZLA ORAL TABLET THERAPY PACK (<i>Apremilast</i>)	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Pimecrolimus</i>	T1	PA
<i>Podofilox External Solution</i>	T1	
RADIAPLEXRX (<i>Wound Dressings</i>)	T1	
REGENECARE (<i>Lidocaine-Collagen-Aloe Vera</i>)	T1	
RENFLEXIS (<i>InFLIXimab-abda</i>)	T1	PA
SANTYL (<i>Collagenase</i>)	T1	
SILIQ (<i>Brodalumab</i>)	T1	PA
<i>Tacrolimus External Ointment</i>	T1	QL (30 GM per 30 days)
<i>Tazarotene External Cream</i>	T1	
<i>Tazarotene External Gel</i>	T1	
<i>ISOTretinoin</i> (Zenatane)	T1	PA
Smooth Muscle Relaxants		
Antimuscarinics		
<i>Darifenacin Hydrobromide ER</i>	T1	PA
<i>Fesoterodine Fumarate ER</i>	T1	PA
<i>FlavoxATE HCl</i>	T1	PA
<i>Oxybutynin Chloride ER</i>	T1	
<i>oxyBUTYnin Chloride Oral Solution</i>	T1	
<i>Oxybutynin Chloride Oral Tablet 5 MG</i>	T1	
OXYTROL (<i>Oxybutynin</i>)	T1	PA
<i>Solifenacin Succinate</i>	T1	
<i>Tolterodine Tartrate</i>	T1	
<i>Tolterodine Tartrate ER</i>	T1	QL (30 EA per 30 days)
<i>Trospium Chloride</i>	T1	PA
<i>Trospium Chloride ER</i>	T1	PA
Genitourinary Smooth Muscle Relaxants		
<i>FlavoxATE HCl</i>	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Oxybutynin Chloride ER</i>	T1	
<i>Oxybutynin Chloride Oral Tablet 5 MG</i>	T1	
OXYTROL (<i>Oxybutynin</i>)	T1	PA
<i>Tolterodine Tartrate</i>	T1	
<i>Trospium Chloride</i>	T1	PA
<i>Trospium Chloride ER</i>	T1	PA
Respiratory Smooth Muscle Relaxants		
<i>Sildenafil Citrate Oral Tablet 20 MG</i>	T1	PA
THEO-24 (<i>Theophylline</i>)	T1	
<i>Theophylline ER Oral Tablet Extended Release 12 Hour 300 MG, 450 MG</i>	T1	
<i>Theophylline ER Oral Tablet Extended Release 24 Hour</i>	T1	
<i>Theophylline Oral Elixir</i>	T1	
Selective Beta-3-Adrenergic Agonists		
GEMTESA (<i>Vibegron</i>)	T1	PA
<i>Mirabegron ER</i>	T1	PA
MYRBETRIQ ORAL SUSPENSION RECONSTITUTED ER (<i>Mirabegron</i>)	T1	PA
Vitamins		
Multivitamin Preparations		
<i>Actical</i>	T1	
<i>B Complex Formula 1 (Lipotrop)</i>	T1	
<i>B Complex-C Oral Tablet</i>	T1	
<i>B Complex-C-Biotin-E-FA</i>	T1	
<i>B Complex-C-Folic Acid</i>	T1	
<i>Balance B-100</i>	T1	
<i>Balance B-50</i>	T1	
<i>B-Complex (Folic Acid)</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>B-Complex/Vitamin C</i>	T1	
<i>B-Complex-C Oral Tablet</i>	T1	
<i>Centravites 50 Plus</i>	T1	
<i>Childrens Chew Multivitamin</i>	T1	
<i>Childrens Chewable Vitamins</i>	T1	
<i>Classic Prenatal</i>	T1	
<i>Complete Natal DHA Oral 29-1-200 & 200 MG</i>	T1	
<i>CVS B Complex Plus C</i>	T1	
<i>CVS One Daily Essential</i>	T1	
<i>CVS Super B Complex/C</i>	T1	
<i>Daily Value Multivitamin</i>	T1	
<i>Daily Vite</i>	T1	
<i>Daily Vites</i>	T1	
<i>Daily-Vite</i>	T1	
<i>Daily-Vite Multivitamin</i>	T1	
<i>DIALYVITE 3000 (B Complex-C-Biotin-E-Min-FA)</i>	T1	
<i>DIALYVITE 800 ORAL TABLET (B Complex-C-Folic Acid)</i>	T1	
<i>DIALYVITE/ZINC (B Complex-C-Zn-Folic Acid)</i>	T1	
<i>ELITE-OB (Prenatal Vit-Iron Carbonyl-FA)</i>	T1	
<i>EQL Prenatal Formula</i>	T1	
<i>Essential One Daily Multivit</i>	T1	
<i>FLINTSTONES/MY FIRST ORAL TABLET CHEWABLE (Pediatric Multiple Vitamins)</i>	T1	
<i>Folbee Plus</i>	T1	
<i>Full Spectrum B/Vitamin C</i>	T1	
<i>GERITOL TONIC (Iron-Vitamins)</i>	T1	
<i>GNP Essential One Daily</i>	T1	
<i>GNP PreNatal</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GUMMI BEAR MULTIVITAMIN/MIN (<i>Pediatric Multivitamin-Minerals</i>)	T1	
<i>Hylavite</i>	T1	
<i>Kobee</i>	T1	
LYSIPLEX PLUS ORAL LIQUID (<i>Multiple Vitamins-Minerals</i>)	T1	
<i>M-Natal Plus</i>	T1	
<i>Multiple Vitamins Oral Tablet</i>	T1	
<i>Multiple Vitamins-Iron Oral Tablet Chewable</i>	T1	
<i>Multi-Vitamin</i>	T1	
<i>Multivitamin Adult Oral Tablet</i>	T1	
<i>Multivitamin Childrens</i>	T1	
<i>Multivitamin Childrens (w/ FA)</i>	T1	
<i>Multivitamin Oral Tablet</i>	T1	
<i>Multivitamin/Fluoride Oral Tablet Chewable 0.25 MG, 0.5 MG, 1 MG</i>	T1	
<i>Nephro Vitamins</i>	T1	
NEPHRO-VITE (<i>B Complex-C-Folic Acid</i>)	T1	
NUTRIVIT (<i>B Complex-Lysine-Min-Fe-FA</i>)	T1	
<i>One-Daily Multi-Vitamin Oral Tablet</i>	T1	
<i>PC Pediatric Tri-Vitamin Drops</i>	T1	
<i>Prenatal Gummies/DHA & FA</i>	T1	
PRENATAL MULTIVITAMIN + DHA (<i>Prenatal MV-Min-Fe Fum-FA-DHA</i>)	T1	
<i>Prenatal One Daily</i>	T1	
<i>Prenatal Oral Tablet 27-0.8 MG, 27-1 MG, 28-0.8 MG</i>	T1	
<i>Prenatal Plus</i>	T1	
<i>Prenatal Vitamin and Mineral</i>	T1	
<i>Prenatal Vitamins Oral Tablet 28-0.8 MG</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Prenatal/Iron</i>	T1	
<i>QC Prenatal</i>	T1	
<i>Quintabs</i>	T1	
RENAL ORAL CAPSULE (<i>B Complex-C-Folic Acid</i>)	T1	
<i>Renal Vitamin</i>	T1	
<i>Rena-Vite</i>	T1	
<i>Rena-Vite Rx</i>	T1	
<i>Reno Caps</i>	T1	
<i>Stress Formula</i>	T1	
<i>Super B Complex/FA/Vit C</i>	T1	
<i>Super B/C</i>	T1	
<i>Super B-Complex + Vitamin C</i>	T1	
<i>Super B-Complex/Vit C/FA</i>	T1	
<i>Support</i>	T1	
SUPPORT-500 (<i>Multiple Vitamins-Minerals</i>)	T1	
THERA (<i>Multiple Vitamin</i>)	T1	
<i>Thrivite Rx</i>	T1	
<i>Triphrocaps</i>	T1	
<i>Tri-Vite Pediatric</i>	T1	
<i>Tri-Vite/Fluoride Oral Solution 0.25 MG/ML</i>	T1	
<i>V-C Forte</i>	T1	
VIC-FORTE (<i>Multiple Vitamins-Minerals</i>)	T1	
VITALETS CHILDRENS ORAL TABLET CHEWABLE (<i>Pediatric Multivit-Minerals</i>)	T1	
<i>WesCaps</i>	T1	
<i>WesTab Plus</i>	T1	
Vitamin A		

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AQUASOL A INTRAMUSCULAR SOLUTION 50000 UNIT/ML (<i>Vitamin A</i>)	T1	
<i>PC Pediatric Tri-Vitamin Drops</i>	T1	
<i>Tri-Vite Pediatric</i>	T1	
<i>Tri-Vite/Fluoride Oral Solution 0.25 MG/ML</i>	T1	
Vitamin B Complex		
<i>B Complex-C Oral Tablet</i>	T1	
<i>B Complex-C-Biotin-E-FA</i>	T1	
<i>B Complex-C-Folic Acid</i>	T1	
<i>B1</i>	T1	
<i>B-1 Oral Tablet 100 MG</i>	T1	
<i>B-12 DOTS (Cyanocobalamin)</i>	T1	
<i>B-12 Oral Tablet 100 MCG, 50 MCG, 500 MCG</i>	T1	
<i>B-12 TR Oral Tablet Extended Release 2000 MCG</i>	T1	
<i>Balance B-100</i>	T1	
<i>Balance B-50</i>	T1	
<i>B-Complex (Folic Acid)</i>	T1	
<i>B-Complex/B-12 Oral</i>	T1	PA
<i>B-Complex/Vitamin C</i>	T1	
<i>B-Complex-C Oral Tablet</i>	T1	
<i>BP Vit 3</i>	T1	
<i>Centravites 50 Plus</i>	T1	
<i>Childrens Chew Multivitamin</i>	T1	
<i>Childrens Chewable Vitamins</i>	T1	
<i>Classic Prenatal</i>	T1	
<i>Complete Natal DHA Oral 29-1-200 & 200 MG</i>	T1	
<i>CVS B Complex Plus C</i>	T1	
<i>CVS B-1</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>CVS B-12 Oral Tablet</i>	T1	
<i>CVS One Daily Essential</i>	T1	
<i>CVS Super B Complex/C</i>	T1	
<i>CVS Vitamin B-12 Oral Tablet Extended Release</i>	T1	
<i>Cyanocobalamin Injection Solution 1000 MCG/ML</i>	T1	
DIALYVITE 3000 (<i>B Complex-C-Biotin-E-Min-FA</i>)	T1	
DIALYVITE 800 ORAL TABLET (<i>B Complex-C-Folic Acid</i>)	T1	
DIALYVITE/ZINC (<i>B Complex-C-Zn-Folic Acid</i>)	T1	
<i>Drospiren-Eth Estrad-Levomefol</i>	T1	
ELITE-OB (<i>Prenatal Vit-Iron Carbonyl-FA</i>)	T1	
ENDUR-ACIN ORAL TABLET EXTENDED RELEASE 500 MG (<i>Niacin</i>)	T1	
<i>EQL Prenatal Formula</i>	T1	
<i>EQL Vitamin B-12</i>	T1	
<i>Essential One Daily Multivit</i>	T1	
FLINTSTONES/MY FIRST ORAL TABLET CHEWABLE (<i>Pediatric Multiple Vitamins</i>)	T1	
<i>Folbee Plus</i>	T1	
<i>Folic Acid Injection</i>	T1	
<i>Folic Acid Oral Tablet 1 MG, 400 MCG</i>	T1	
<i>Folplex 2.2</i>	T1	
<i>Full Spectrum B/Vitamin C</i>	T1	
GERITOL TONIC (<i>Iron-Vitamins</i>)	T1	
<i>GNP Essential One Daily</i>	T1	
<i>GNP PreNatal</i>	T1	
<i>GNP Vitamin B-1</i>	T1	
<i>GNP Vitamin B-12 Oral Tablet</i>	T1	
<i>Hematinic Plus Vit/Minerals</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Hematinic/Folic Acid</i>	T1	
HEMATOGEN FA (<i>Fe Fum-Vit C-Vit B12-FA</i>)	T1	
<i>Hydroxocobalamin Acetate</i>	T1	
<i>Hylavite</i>	T1	
<i>Kobee</i>	T1	
<i>KP Folic Acid Oral Tablet 1 MG</i>	T1	
LEDERLE LEUCOVORIN (<i>Leucovorin Calcium</i>)	T1	
<i>Leucovorin Calcium Oral Tablet 5 MG</i>	T1	
METAFOLBIC (<i>L-Methylfolate-B12-B6-B2</i>)	T1	
<i>M-Natal Plus</i>	T1	
<i>Multivitamin Adult Oral Tablet</i>	T1	
<i>Multivitamin Childrens</i>	T1	
<i>Multivitamin Childrens (w/ FA)</i>	T1	
<i>Multivitamin/Fluoride Oral Tablet Chewable 0.25 MG, 0.5 MG, 1 MG</i>	T1	
<i>Nephro Vitamins</i>	T1	
NEPHRO-VITE (<i>B Complex-C-Folic Acid</i>)	T1	
<i>Neurin-SL</i>	T1	
<i>Niacin (Antihyperlipidemic)</i>	T1	
<i>Niacin ER (Antihyperlipidemic)</i>	T1	PA
NIAVASC (<i>Niacin</i>)	T1	
NUTRIVIT (<i>B Complex-Lysine-Min-Fe-FA</i>)	T1	
<i>Poly-Iron 150 Forte</i>	T1	
<i>Prenatal Gummies/DHA & FA</i>	T1	
PRENATAL MULTIVITAMIN + DHA (<i>Prenatal MV-Min-Fe Fum-FA-DHA</i>)	T1	
<i>Prenatal One Daily</i>	T1	
<i>Prenatal Oral Tablet 27-0.8 MG, 27-1 MG, 28-0.8 MG</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Prenatal Plus</i>	T1	
<i>Prenatal Vitamin and Mineral</i>	T1	
<i>Prenatal Vitamins Oral Tablet 28-0.8 MG</i>	T1	
<i>Prenatal/Iron</i>	T1	
<i>Pyridoxine HCl Injection</i>	T1	
<i>QC Prenatal</i>	T1	
<i>Quintabs</i>	T1	
RENAL ORAL CAPSULE (<i>B Complex-C-Folic Acid</i>)	T1	
<i>Renal Vitamin</i>	T1	
<i>Rena-Vite</i>	T1	
<i>Rena-Vite Rx</i>	T1	
<i>Reno Caps</i>	T1	
<i>Stress Formula</i>	T1	
<i>Super B Complex/FA/Vit C</i>	T1	
<i>Super B/C</i>	T1	
<i>Super B-Complex + Vitamin C</i>	T1	
<i>Super B-Complex/Vit C/FA</i>	T1	
SUPPORT-500 (<i>Multiple Vitamins-Minerals</i>)	T1	
<i>Thiamine HCl Injection</i>	T1	
<i>Thiamine HCl Oral</i>	T1	
<i>Thiamine Mononitrate Oral</i>	T1	
<i>Thrivite Rx</i>	T1	
<i>Trigels-F Forte</i>	T1	
<i>Triphrocaps</i>	T1	
<i>V-C Forte</i>	T1	
VIC-FORTE (<i>Multiple Vitamins-Minerals</i>)	T1	
<i>Vitamin B 12 Oral Tablet</i>	T1	
<i>Vitamin B Complex Oral Tablet</i>	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Vitamin B1 Oral Tablet 100 MG</i>	T1	
<i>Vitamin B-1 Oral Tablet 100 MG</i>	T1	
<i>Vitamin B-12 ER Oral Tablet Extended Release 2000 MCG</i>	T1	
<i>Vitamin B12 TR Oral Tablet Extended Release 2000 MCG</i>	T1	
<i>WesCaps</i>	T1	
<i>WesTab Plus</i>	T1	
Vitamin C		
<i>Ascorbic Acid Injection</i>	T1	
<i>B Complex-C Oral Tablet</i>	T1	
<i>B Complex-C-Biotin-E-FA</i>	T1	
<i>B Complex-C-Folic Acid</i>	T1	
<i>B-Complex/Vitamin C</i>	T1	
<i>B-Complex-C Oral Tablet</i>	T1	
<i>Childrens Chew Multivitamin</i>	T1	
<i>Childrens Chewable Vitamins</i>	T1	
<i>CVS B Complex Plus C</i>	T1	
<i>CVS Super B Complex/C</i>	T1	
<i>DIALYVITE 3000 (B Complex-C-Biotin-E-Min-FA)</i>	T1	
<i>DIALYVITE 800 ORAL TABLET (B Complex-C-Folic Acid)</i>	T1	
<i>DIALYVITE/ZINC (B Complex-C-Zn-Folic Acid)</i>	T1	
<i>FLINTSTONES/MY FIRST ORAL TABLET CHEWABLE (Pediatric Multiple Vitamins)</i>	T1	
<i>Folbee Plus</i>	T1	
<i>Full Spectrum B/Vitamin C</i>	T1	
<i>GUMMI BEAR MULTIVITAMIN/MIN (Pediatric Multivit-Minerals)</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Hematinic Plus Vit/Minerals</i>	T1	
HEMATOGEN FA (<i>Fe Fum-Vit C-Vit B12-FA</i>)	T1	
<i>Hylavite</i>	T1	
<i>Multivitamin Childrens</i>	T1	
<i>Multivitamin Childrens (w/ FA)</i>	T1	
<i>Nephro Vitamins</i>	T1	
NEPHRO-VITE (<i>B Complex-C-Folic Acid</i>)	T1	
<i>PC Pediatric Tri-Vitamin Drops</i>	T1	
RENAL ORAL CAPSULE (<i>B Complex-C-Folic Acid</i>)	T1	
<i>Renal Vitamin</i>	T1	
<i>Rena-Vite</i>	T1	
<i>Rena-Vite Rx</i>	T1	
<i>Reno Caps</i>	T1	
<i>Stress Formula</i>	T1	
<i>Super B Complex/FA/Vit C</i>	T1	
<i>Super B/C</i>	T1	
<i>Super B-Complex + Vitamin C</i>	T1	
<i>Super B-Complex/Vit C/FA</i>	T1	
SUPPORT-500 (<i>Multiple Vitamins-Minerals</i>)	T1	
<i>Trigels-F Forte</i>	T1	
<i>Triphrocaps</i>	T1	
<i>Tri-Vite Pediatric</i>	T1	
<i>Tri-Vite/Fluoride Oral Solution 0.25 MG/ML</i>	T1	
VITALETS CHILDRENS ORAL TABLET CHEWABLE (<i>Pediatric Multivit-Minerals</i>)	T1	
<i>Vitamin B Complex Oral Tablet</i>	T1	PA
<i>WesCaps</i>	T1	
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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Actical</i>	T1	
<i>Calcitriol Oral</i>	T1	
<i>Doxercalciferol Oral Capsule 0.5 MCG, 2.5 MCG</i>	T1	
<i>Ergocalciferol Oral Capsule</i>	T1	
FOSAMAX PLUS D ORAL TABLET 70-2800 MG-UNIT <i>(Alendronate-Cholecalciferol)</i>	T1	PA
<i>PC Pediatric Tri-Vitamin Drops</i>	T1	
<i>Tri-Vite Pediatric</i>	T1	
<i>Tri-Vite/Fluoride Oral Solution 0.25 MG/ML</i>	T1	
<i>Vitamin D (Ergocalciferol) Oral Capsule 1.25 MG (50000 UT)</i>	T1	
Vitamin E		
<i>B Complex-C-Biotin-E-FA</i>	T1	
DIALYVITE 3000 (<i>B Complex-C-Biotin-E-Min-FA</i>)	T1	
Vitamin K Activity		
<i>Multivitamin Adult Oral Tablet</i>	T1	
<i>Phytonadione Injection Solution 1 MG/0.5ML, 10 MG/ML</i>	T1	
<i>Phytonadione Oral</i>	T1	
<i>Vitamin K1 Injection Solution 1 MG/0.5ML, 10 MG/ML</i>	T1	

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